VA CARE OF THE CHRONICALLY MENTALLY ILL

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JUNE 29, 1993

Printed for the use of the Committee on Veterans' Affairs

Serial No. 103–21

U.S. GOVERNMENT PRINTING OFFICE
75–468 O WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-043564-1

COMMITTEE ON VETERANS' AFFAIRS

G.V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
DOUGLAS APPLEGATE, Ohio
LANE EVANS, Illinois
TIMOTHY J. PENNY, Minnesota
J. ROY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOSEPH P. KENNEDY II, Massachusetts
GEORGE E. SANGMEISTER, Illinois
JILL L. LONG, Indiana
CHET EDWARDS, Texas
MAXINE WATERS, California
BOB CLEMENT, Tennessee
BOB FILNER, California
FRANK TEJEDA, Texas
LUIS V. GUTIERREZ, Illinois
SCOTTY BAESLER, Kentucky
SANFORD BISHOP, Georgia
JAMES E. CLYBURN, South Carolina
MIKE KREIDLER, Washington
CORRINE BROWN, Florida

BOB STUMP, Arizona
CHRISTOPHER H. SMITH, New Jersey
DAN BURTON, Indiana
MICHAEL BILIRAKIS, Florida
THOMAS J. RIDGE, Pennsylvania
FLOYD SPENCE, South Carolina
TIM HUTCHINSON, Arkansas
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JACK QUINN, New York
SPENCER BACHUS, Alabama
JOHN LINDER, Georgia
CLIFF STEARNS, Florida
PETER T. KING, New York

MACK FLEMING, *Staff Director and Chief Counsel*

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

J. ROY ROWLAND, Georgia, *Chairman*

DOUGLAS APPLEGATE, Ohio
JOSEPH P. KENNEDY, II, Massachusetts
JILL L. LONG, Indiana
CHET EDWARDS, Texas
BOB CLEMENT, Tennessee
BOB FILNER, California
FRANK TEJEDA, Texas
LUIS V. GUTIERREZ, Illinois
SCOTTY BAESLER, Kentucky
SANFORD BISHOP, Georgia
MIKE KREIDLER, Washington
CORRINE BROWN, Florida

CHRISTOPHER H. SMITH, New Jersey
BOB STUMP, Arizona
DAN BURTON, Indiana
MICHAEL BILIRAKIS, Florida
TIM HUTCHINSON, Arkansas
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JOHN LINDER, Georgia

CONTENTS

June 29, 1993

MATERIAL SUBMITTED FOR THE RECORD

VA CARE OF THE CHRONICALLY MENTALLY ILL

TUESDAY, JUNE 29, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to recess, at 9:40 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (chairman of the subcommittee), presiding.

Present: Representatives Rowland, Applegate, Kennedy, Long, Edwards of Texas, Clement, Filner, Tejeda, Gutierrez, Baesler, Bishop, Kreidler, Smith, Hutchinson, Everett, Buyer, Linder.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. We will now move to the hearing that we had planned for this morning.

On April 28 a hearing on VA's role within a national health care reform program identified areas in which the VA has developed a nationally recognized expertise. Several of the witnesses cited mental health care as among areas of particular VA strength. Many view the VA as a system which provides an array of mental health care programs with no real counterpart. A strong VA role in mental health care is certainly important in light of the heavy burden of chronic mental illness among the veterans that the VA serves.

What are the veterans' needs? Data from the National Institute of Mental Health indicate that over 50 percent of all veterans needing mental health care receive that care from the VA. In contrast, veterans with medical and surgical problems are far more likely to use community resources. Given veterans' heavy reliance on the VA for mental health care, the scope of such coverage under national health care reform will become critical. Many of us question whether national health care reform will offer as extensive an array of mental health care services, particularly for the chronically ill, as the VA provides. If not, it would seem likely that VA will continue to serve a very critical need for the chronically mentally ill.

It is important, in any case, that we examine critically how effective a job VA is doing for these veterans. In recent years, selected VA mental health programs have been singled out for enriched funding. Accordingly, the Department has fared relatively well in funding support for PTSD, substance abuse programs, and care of the homeless.

But what about other chronically mentally ill veterans? We will learn this morning that there has been a persistent erosion of the funding available for those patients. Yet of veterans under VA treatment for schizophrenia, for example, almost half are service-connected for that condition.

Historically, VA's primary emphasis in caring for the chronically mentally ill appears to have been long-term institutional care. We have seen the development within the VA of a range of alternative treatment programs for care of the chronically mentally ill. Yet 80 percent of VA mental health dollars remain devoted to inpatient care.

State mental health agencies, in contrast, place far greater emphasis on outpatient care. This hearing provides us an opportunity to examine the extent to which VA facilities offer the mentally ill needed continuity of care for their mental illnesses, the extent to which there are enough programs and capacity for effective rehabilitation, and the relative funding commitment within the VHA budget for care of chronic mental illness.

While we know that the VA budget has not kept pace with the rising cost of care or with the full spectrum of veterans' needs, there are real questions about the priorities reflected in the allocation of available funding. We must ask whether the priority assigned to care of the chronically mentally ill is commensurate with the numbers suffering such illnesses and with the treatment and rehabilitation options that could be mobilized. Or, as some suggest, does tertiary medical and surgical care win funding out of proportion to real patient need? These are important questions to tackle on the eve of both national health care reform and possible restructuring in the VA.

We are fortunate this morning to have a number of distinguished experts and advocates for the chronically mentally ill who can help us as we wrestle with our questions. So I am particularly pleased to welcome this morning Marcy Kaptur, who is an outstanding former subcommittee chair of the Veterans Affairs Committee and she has been a long-time advocate for the mentally ill. She will be our opening witness.

But before calling on Marcy, I want to recognize my friend Chris Smith, who is the ranking minority member of the subcommittee, for any remarks he might have.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. Mr. Chairman, largely unrecognized by most Americans is the fact that the VA remains the largest provider of mental health services in the United States. We know that the VA psychiatric patient workload has increased significantly over the last several years. Unfortunately, like the VA's medical care account in general, funding levels have not been sufficient to support these increases. In fact, inpatient psychiatric care continues to get less than 20 percent of the VA's inpatient funding despite the fact that psychiatric patients make up more than 33 percent of all VA patients at any given time. While there is no requirement for funding proportionality among VA programs, the community needs to be reassured that an adequate dis-

tribution of funds is being maintained between medical care programs.

Today, the subcommittee will review the various psychiatric services and programs provided by the VA in order to evaluate the ability of the VA to provide high quality psychiatric care to veterans. This is particularly important in light of the national health care reform initiatives. As the chairman mentioned, it is not clear whether mental health care services will be included in National Health Care Reform, and if they are included to what extent under the Clinton plan, in which case the VA will be the primary source of treatment for this population.

Therefore, it becomes critically necessary to decide if improvements or expansions to VA's current methods of care are needed in order to provide for the future psychiatric health care needs of veterans.

Mr. Chairman, I would like to join you as well in welcoming our very distinguished colleague from Ohio, Marcy Kaptur, a former subcommittee chair who has done yeoman's work and has been a leader, particularly in this area of mental health care, and I too want to join the majority in welcoming her to our subcommittee this morning.

Mr. ROWLAND. Marcy, if you would come forward we would be most appreciative.

Are there any other members who have any comments to make at this time?

[No response.]

Mr. ROWLAND. Marcy, thank you very much for being here this morning. We are all aware of the long interest that you have had in mentally ill people, and so we look forward to your testimony this morning.

STATEMENT OF HON. MARCY KAPTUR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. KAPTUR. Thank you, Mr. Chairman, very much. And, Mr. Smith, and members of the committee, it is always good to be back in my home committee. And I want to especially thank you for your leadership, Mr. Chairman. It is really good to see you in that chair today and holding these particular hearings on a topic that I think has been long ignored, not just by the Department of Veterans Affairs, but by our Nation, in many ways. And may I offer my wholehearted support to you and the members of your committee and cooperation in my own role over on the VA HUD Independent Agencies Subcommittee of Appropriations as you assess the care for veterans who are mentally ill and in need of treatment.

In my opinion, there is no more overlooked set of illnesses than those involving the chemistry and function of the brain. And though I am going to summarize my testimony this morning, I would ask that it be submitted and included in the record in its entirety.

Mr. ROWLAND. Without objection.

Ms. KAPTUR. The need to address this issue is evidenced by the fact that 40 percent of the veterans treated at VA medical facilities have been diagnosed with psychiatric disorders, and each year ap-

proximately one-third of the hospital beds in VA facilities are occupied by patients with these illnesses.

I am going to focus my attention on three areas this morning. First of all, the support of expanded VA mental illness research, especially coordinating with the NIH, during this Decade of the Brain. Secondly, rehabilitation services for homeless chronically mentally ill veterans, and transitional housing which would allow for the monitoring of veterans treated for mental illness. So I am going to focus my recommendations in those three areas.

First, let me address the issue of research so fundamental to achieving breakthroughs to properly treat this set of illnesses. About 40 percent of VA patients currently receive treatment for mental illness. Yet, if you look at the VA's research budget, just a little over 11 percent of the fiscal year 1992 VA medical research budget, the latest year for which we have figures, was spent in investing in research in these areas. That surprised me when I first learned it as a member of this particular committee, and we have been pushing and pushing and pushing to try to get more attention over there to investing in research in psychiatric illnesses.

One of the aspects I would urge your committee to take a look is that even the people whom the VA puts on their peer review groups to select research awards seriously underrepresent those whose background is in psychiatry and medicine. I remember one time when I served on the Veterans' Affairs Committee psychiatrists and neurologists I think only comprised like 2 of maybe 12 or 20 people on given review committees which select the VA's research priorities, and it was very difficult for them even to see the subset of illnesses as worthy of additional attention. Thus, it was not surprising to me that the VA research dollars were allocated in the way that they were.

In my judgment, there is a serious need to realign VA research priorities to parallel the characteristics of the patients treated. Despite the fact that only 11.2 percent of VA medical research is focused in this area, nonetheless the VA has played a role along with other researchers in our society in trying to help veterans become functional again. Many of them would have spent the rest of their lives in hospitals. You all have been through as many VA hospitals as I have been through. You have met many of these patients, many of them disabled by hallucinations, crippling paranoia, unremitting depression or gut-wrenching panic disorders.

There has been a lot of focus on PTSD by this committee, and that was certainly an important area on which to focus. But it is not the only one for which our society has rather inadequate answers. And I think that I would encourage in any way that I could the committee during this Decade of the Brain to, perhaps, give more encouragement and more life to the efforts within the VA itself to, perhaps for the first time in recorded history, find answers for treatment of these very disabling illnesses.

Let me mention a recent NIMH study that was prepared for the Senate Appropriations Committee that indicates, for example, with clozapine, one of the drugs that has been developed, nearly one-third of the people who have been diagnosed with schizophrenia and who had previously been immune and unresponsive to other treatments responded. One of the problems with clozapine, as with

so many of these drugs, is serious side effects—twitching or headaches or nausea—and we need research to help us fine tune these medications, including clozapine, to get rid of those side effects.

And I think there is no better time than during this Decade of the Brain to increase support and attention to serious mental illness, particularly additional research and treatments for schizophrenia and bipolar disorder.

Now, a coordinated emphasis on psychiatric research by the VA and the NIMH would help a great deal. In fact, in the bill that we will be voting on on the floor today, the VA HUD appropriations bill for 1994, we were able to get language that encourages the VA and NIMH research review committees to jointly work together to submit a report on ways to improve the coordination of psychiatric research across the Government of the United States.

Let me just mention that research directly leads to treatments, and not only a humane existence for millions of our citizens—it is estimated that at least 10 percent of our citizenry is affected by one of these subset of illnesses—but also incredible cost savings that result from proper treatment. The NIMH study indicates that success rates once patients are treated for panic and bipolar disorders are 80 percent; for major depression, 65 percent, and schizophrenia, 60 percent. These were illnesses that people thought there were no answers to in past years. But if you look at where we as a country invest money, and we hear a lot more about in the press, for example, angioplasty or atherectomy, which are two cardiovascular treatments, success rates there are just 41 percent and 52 percent, respectively.

So this is an area where we know that we would have good results if we but had better answers, and it is estimated that the cost to our economy of not treating these illnesses is over $136 billion a year. In fact, NIMH, from some data that is prepared, shows that because of the introduction of lithium, over $40 billion has been saved for our country, not just in people being able to go back to work. But if you think about the cost of storing sick people on VA disability, on SSDI, on workman's compensation at the local level, and the host of ways that we store people rather than treat people, you can imagine the cost savings to our country.

I might recommend to you on model, although I wouldn't recommend copying it exactly. When we needed coordinated research efforts in our country in the area of geriatrics the VA was a leader in setting up the GRECCs—the geriatric research education and clinical centers—around the Nation. There had been bills introduced in past Congresses to repeat that structure in the area of mental illness and treatment, and there are currently three centers around our country supported by the VA which directly do clinical research in schizophrenia. I wouldn't recommend you copy the GRECCs exactly, but we really need to have focus within the VA system and more coherent attention across the various research entities of the VA paid to mental illness and to treatment.

Let me move on because I know the committee has really been wonderful in trying to increase support for VA's health care for homeless veterans, and I think that this is also very important. We know that at least a third of our Nation's homeless are veterans, and I know you have veterans in your district as I do who are liv-

ing along river banks and under bridges and so forth, many suffering not just from mental illness but present with dual diagnoses of mental illness plus drug abuse or alcohol abuse. Let me just give you figures for my own area of northwest Ohio, which is not like New York City. It is a community of about 400,000 people.

We have identified over 4,500 chronically homeless individuals, and we expect approximately 1,500 to 1,700 of those are veterans. Many of them present with dual diagnoses, as I have mentioned. And by working with various community organizations, our veterans clinic has begun for the first time during this past 6-month period to be able to go out and send outreach workers into the community to homeless shelters, to doorways, to bridges, and to river banks to try to locate people and to begin to treat them.

We expect that we will be able to treat in our area over 600 homeless chronically mentally ill veterans each year, and we know that since this program began at the VA over 30,000 homeless veterans suffering from psychiatric and substance abuse have been treated.

I would like to tell you a story, though, if you have not personally experienced this, about what happened with just one story. Right before Thanksgiving, our newspaper, as you would figure, had a lot of compelling stories on the front pages, and they sent one of the reporters around town who found a homeless individual living along the river banks of the major river in our community. And so the day before Thanksgiving a story appeared in our paper about a man named Phil, who for a long time had lived in a tent along the river banks of the Maumee River.

And the story was published, contrasting how Phil was spending his Thanksgiving with the way everybody else in the community was, and a friend of his from grade school saw this picture in the paper and remembered his friend that he had been in the eighth grade with, so he went downtown to try to find him. And he took him in and began to try to help Phil receive help, and Phil needed all kinds of help. He needed to be cleaned up. He needed to get medical attention. He had no benefits of any kind at that point, so this man went around calling doctors, saying "Would you examine him for free?" trying to get him fed properly and a decent place to stay at night. And he literally begged on his friend's behalf for help.

Right after Thanksgiving I think it was, or Christmas, they came to see me in my office, and as we were sitting I remembered the story from the newspaper, and they began telling me what they had been through in trying to get Phil back on his feet. And Phil was not real communicative, his friend was more communicative. And during the conversation the man who had found him said to me, "Well, Marcy, we now have another problem. He has been diagnosed recently as a paranoid schizophrenic." I said, "Oh, my goodness." I said, "Are you receiving treatment?" And they said, No, we're trying to find doctors who can really help him.

And I said, "By chance, is Phil a veteran?" And this friend of his who had been taking care of him looked at him and he said, "I don't know. Phil, are you a veteran?" Phil said, "I'm Army." And he spoke up and then began a process where we could get him ad-

mitted to our VA clinic and begin to treat this man who was so seriously ill.

But it was amazing to me. I mean he is just one of thousands in our community who was lucky enough to have a story printed about him in the newspaper. Our traditional services are so inadequate in reaching individuals like this. So he at least now has access to proper care.

But the problems of housing for individuals like this are so difficult, and that is the next problem to which I wish to move. And let me say I first became aware of this on a trip that this committee took several years ago to Chicago to Hines Medical Center on the West Side of Chicago. When I was walking through the emergency room there was a social worker out there in the hospital by the name of Anna Pope, and as we were being escorted through the hospital this man, who was obviously having difficulties in the admitting room there, was brought in, and she said, "Oh, yes, we know him." I said, "How do you know him?" She said, "It's his 17th admittance." I said, "Seventeenth admittance?" I mean you would ask yourself the same question. And she said, "Oh, yes. And I don't remember his name now," but she said, "He comes in here, you know, and we get him on his meds, and then he goes back out into Chicago and a year later maybe the cops drop him off or he finds his way out here by hiking back to the hospital."

And the day we were there this particular hospital was decommissioning some of its single story units that had been old ward units or something, and I said to this Anna Pope, "Why couldn't you turn that into some housing since it is going to be ripped down anyway, so veterans like this would be able to have some type of shelter where their meds could be monitored?" And, of course, that was outside her jurisdiction because she worked in social work, not housing, and I guess the social work department of the VA is on the third floor in the Central Office and the housing division is on the fourth floor and they don't necessarily always talk to one another.

It was just the most incredible situation—and I could just imagine in Chicago how many people there actually were faced with that situation. So I am very supportive and will try to be helpful to this committee in trying to expand funds to implement the Homeless Veterans Comprehensive Service Program authorized by your committee last year. And you and I all know how effective this could be, but I continue to see the disaggregation of services and opportunities for treatment for mental illness that when you get right down to on the local level are really very difficult to put together. And I think with programs like this, when I have seen what has happened with our VA clinic and how wonderful they have networked with other organizations in our community for the first time, we have a chance to really deal with this problem.

So I thank you so much for your attention and I am happy to answer any questions, and just want to urge you on in the strongest way that I can to continue on in your efforts in this area, Dr. Rowland.

[The prepared statement of Congresswoman Kaptur appears on p. 45.]

Mr. ROWLAND. Marcy, thank you very much for that excellent testimony. You covered three very important areas. The area of research particularly. As you know, there was $26 million that was taken out of the VA budget for research. But now that has been put back in plus an additional $20 million, thanks to Chairman Stokes and your efforts. We are very pleased that that has happened because if you don't have research you can't develop the kind of knowledge that is needed to treat any illness, and certainly the concepts of mental illness have changed drastically over the past decade or so. Now a chemical etiology has been discovered for so many of those illnesses, and the drug clozapine, which you mentioned, for the use in schizophrenia is a perfect example of that.

I was listening to your story about the homeless fellow that was found just before Thanksgiving. Are you aware that there are certain times of the year that more people come in and are diagnosed with mental illness, and that time of the year is at Thanksgiving and Christmas? Those are the times of the year that people come in more who are mentally ill, because during that particular time of the year they fall over the edge.

So the environment has a great deal to do with mental illness and how well individuals are able to control their situation. There are so many people that have mental illness that are able to control the problem, but something could happen to kick them over

So I want to thank you very much for that wonderful testimony this morning.

Ms. KAPTUR. Thank you, Mr. Chairman. If the gentleman would yield, just for one second. You reminded me of another factor that I am sure is repeated in your own communities.

I represent a community that has a federally certified local county jail, which means it has to have pretty high standards, and our county sheriff has been given awards because we have at least a whole floor there devoted to some treatment for prisoners who actually are mentally ill. It is terrible that people end up in that situation, and I am not saying the treatment isn't good but it certainly isn't the best. And I know that we have people stored all over this country who actually need medical treatment, and having learned more about this set of illnesses I would say that there is a discrete number of physicians in this country that actually have the training and the experience to properly medicate and treat these patients with proper doses and medicine and understand all the new drug technologies and so forth.

We have seen situations in our community where many of our prisoners as well as citizens who didn't end up in prison cannot be treated properly in a city of 400,000 people, and we have had to send them to Cleveland to Brecksville, one of the VA facilities there which has a relationship with the Case Western Reserve University where a lot of path-breaking research is being done on new drugs and drug treatments.

But I have been somewhat taken aback—I am not a physician, so I wouldn't have known this—that not all physicians have the ability to treat patients with these conditions, and in fact many times improperly treat them. I am sure the VA can do a lot in its residency training and through many of our VA hospitals try to get more physician training in this area since so many of our doctors

spend their early years in the VA system. But I have been shocked many times by what I have seen in terms of treatment.

Mr. ROWLAND. Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman. Knowing you, Marcy, for so many years and knowing of your very keen sense of compassion it was not surprising to hear you relate that story about Phil, which is casework at its best—helping someone who is in dire straits. And you raised the very important question, how many Phils are being overlooked and fall between the cracks and do not get the kind of care that they need when mental illness manifests itself?

It is also reassuring knowing that we have such a strong advocate for veterans in general, and those afflicted with mental illness in particular, serving on the Appropriations Committee. I wish you well in that endeavor, trying to keep attention and focus, as we will try on this committee.

It is very good to see you again, and thank you for your testimony.

Ms. KAPTUR. Thank you so much, Mr. Smith. It is always a pleasure to work with you.

Mr. ROWLAND. Any other members have any comments or questions? Mr. Edwards.

Mr. EDWARDS of Texas. Marcy, one of the terribly frustrating things to me is that with the proper treatment of lithium we can deal with manic depression in a fairly effective way, and it is so difficult to get the patients who need to stay on lithium to keep taking it.

I am curious. Do you know how the VA deals with manic depression, and do we deal with that on an outpatient basis once they have gotten the inpatient care they need to get stabilized? Or do you have any sense of whether we are effective in the treatment of manic depression through the use of lithium in our VA health care system?

Ms. KAPTUR. I think that is a very good question, Mr. Edwards. Probably others in the audience today could better answer that question. Dr. Paul Errera is here, someone for whom I have the greatest respect because of his path-breaking and largely unrecognized work in this area.

I can't speak specifically just about the VA but my own sense, and this is not to condemn the medical community of the United States, but there has been so much new information, new drugs, new treatments that have come forward, that my sense is that the larger share of the medical community is not equipped to administer drugs and to know the latest treatments.

Now, I am not saying nothing is done—lithium is one that is used and works on maybe a third of the patients or 50 percent of the patients. It doesn't work for all patients. And when they have to find alternative drugs many times the physicians sort of experiment on their patients unless they are affiliated with a center where they are highly sophisticated in administering these drugs at the proper dosages.

And I think what often happens, one of the reasons patients fall off, and this is like the man that I saw in Chicago, especially if they are older, and they have learned not to trust the doctor be-

cause they have been given the wrong medicines. It is much more difficult to treat them. And they have to go through a period where they gain trust for the doctor and trust for the treatment. If they are younger, 18, 19 and are being treated for the first time and it works, they develop a greater sense of confidence. But as the patient ages and has been mistreated many times and, you know, they are afraid of the medication, then I would say either the VA or any other hospital or medical center wouldn't get as responsive a patient.

So I think one of the things we have to do, and this is why I recommend certain centers in the same way as we refer people for PTSD, places where we could train physicians so they would know the most modern meds, where they would know contacts in their own field. So many of them still do psychological counseling, which is important, but that is not going to deal with, really, the serious medical illnesses that these patients have. Many of our physicians need some updated training and they need to work with others who really know how to administer the medications.

And I would fault not just the VA but our society in general, our medical system, for not making it easy for patients to be treated by physicians who really are the most up-to-date.

I know I was surprised to talk to some of the family physicians in my own community and have heard from them, and maybe you can check because I just can't believe these statistics—they have told me that 70 percent of the people that come in their offices, just doctors in the local community, 70 percent of the people who come in there really don't have anything wrong with them. They may complain of a stomach ache. They may complain of heart disease or something else. But their problems are really psychiatric in nature. And they spend an enormous amount of time dealing with these people, and most of these physicians don't have the training to deal with these other sets of illnesses.

So my sense is that our medical community has to take giant steps beyond where it is today in getting proper treatment to these patients.

Mr. EDWARDS of Texas. Thank you very much. Appreciate your efforts.

Mr. ROWLAND. Anyone else?

[No response.]

Mr. ROWLAND. Marcy, thank you so very much. We really appreciate it.

Ms. KAPTUR. Thank you all very much.

Ms. LONG. Mr. Chairman? I arrived just at the end of the mark-up and at the beginning of the hearing, and I would ask unanimous consent that I be recorded as a yes on the legislation.

Mr. ROWLAND. All right. Very well. And you would like to have your name as a cosponsor on the legislation as well.

Ms. LONG. Yes, sir.

Mr. ROWLAND. Okay. Without objection.

Mr. KREIDLER. Mr. Chairman, I would make the same request, if I may.

Mr. ROWLAND. I beg your pardon?

Mr. KREIDLER. I would like to make the same request.

Mr. ROWLAND. Without objection.

Mr. ROWLAND. Our next panel is Dr. Spencer Falcon, who is chairman of the VA Long-Term Mental Health Enhancement Committee; Dr. John O. Lipkin, who is chief of staff of VA Medical Center at Perry Point, MD; and Dr. John A Talbott, who is professor and chairman of the Department of Psychiatry at University of Maryland.

Gentlemen, thank you all very much for being here this morning. We do appreciate you taking the time to come and help us with this most difficult problem.

We would ask that each of you limit your formal presentation to 5 minutes, if you will, and your entire statement will be made a part of the record.

Dr. Falcon, welcome and you may proceed.

STATEMENTS OF SPENCER FALCON, M.D., CHAIRMAN, VA LONG-TERM MENTAL HEALTH ENHANCEMENT COMMITTEE; JOHN O. LIPKIN, M.D., CHIEF OF STAFF, VA MEDICAL CENTER, PERRY POINT, MD; AND JOHN A. TALBOTT, M.D., AMERICAN PSYCHIATRIC ASSOCIATION, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MARYLAND

STATEMENT OF SPENCER FALCON, M.D.

Dr. FALCON. Thank you very much, Mr. Chairman. Dr. Rowland, members of the committee, I am Spencer Falcon. I am the chairman of the Long-term Mental Health Enhancement Program Work Group, and I am also chairman of the VA's Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder. I am pleased to appear before you today to present and discuss concerns regarding the care of chronically mentally ill patients in the veterans' health care system.

Mental health services in the VA have shown great leadership in the development of proactive programs that have been tailored to the specific needs of veteran patients. Our problem has not been a lack of innovation or commitment on the part of VA mental health providers, but an inadequacy of funding of mental health services in VA as compared to funding for tertiary medical and surgical services.

In the 10 years that I have held clinical executive positions within the VA I have been struck, struck by the lack of support for mental health and substance abuse treatment. I base this observation on the fact that new programming in various mental health areas has been created and funded by Congress or by the White House as overbudget allocations. There has been no substantial redirection of dollars from within the Department to these areas. Why is that? I feel the answer lies in a systemwide bias toward academic affiliated high tech tertiary medical centers and away from hospitals and programs where the principal mission is to treat the chronically mentally ill patient.

Consistent with this history, the work group that I chair resulted from an above-budget $6 million appropriation for the VA in fiscal year 1991. We directed that towards improving clinical program and the quality of life for chronically mentally ill patients who are treated in the VA's 29 long-term psychiatric facilities and to evalu-

ate the effectiveness of these pilot projects funded through the appropriations. You are going to hear about one of these today with Bonnie Riley's presentation on Topeka.

Much work has been done in the VA over the past few years to address the specific needs of patients suffering from certain mental disorders, particularly PTSD and substance abuse, homeless chronically mentally ill, and others. In many instances, these above-budget appropriations have directed funding toward the care of these and other populations that have a particular need that was identified.

These additional programs have made a tremendous difference in the care of patients with PTSD and alcohol abuse and the HCMI patients. At the same time, however, there has been a persistent erosion of resources available for patients who form the core of our mental health treatment system, the chronically mentally ill.

There have been a number of statistics already quoted today. Just to reiterate, mental disorders account for about 44 percent of all patient days in the VA medical center, and schizophrenia and other major psychotic disorders account for 65 percent of those total mental health days. That means that a huge portion of our primary job is related to mental health. Nearly half of our total psychiatric beds are located in these 29 or 30 long-term psych institutions, and these are the institutions that are covered by this Long-Term Mental Health Enhancement Program.

These facilities in addition to providing referral services for the Nation on a hospital, cluster and regional basis also are responsible for providing all of the medical care for these patients. One of our principal difficulties has been assuring that adequate medical services are available to aging veterans with chronic mental illness such as schizophrenia and being assured that these particular medical care facilities have an adequate array of physicians, laboratory and other diagnostic capabilities to be able to provide a full spectrum of primary and secondary services to these patients.

There is evidence from a recent survey that we did out of Ann Arbor that care in these facilities suffers from inadequate funding when compared to the funding allocated for tertiary care facilities whose primary interest is the care of the medical and surgical cases and that have only a secondary mission for mental health. This malproportioning is clearly evident when looking at funding for high cost, high tech equipment and other activities.

In the competition for funding among programs and different facilities, it has been particularly difficult for psychiatric services to achieve adequate funding when compared to the medical and surgical services. The average daily census of the VA psychiatric bed section has increased from 31 percent in fiscal year 1991 to 35 percent in fiscal year 1994, while patients in surgical and intermediate bed sections have accounted for a subsequent decrease in the population.

However, psychiatric bed sections only receive 20 percent of the total dollars obligated for care. Chronically mentally ill patients usually do not die from their mental disorders. They become more aged, physically frail and require more resources to support them.

Aggressive and well-meant initiatives such as the ones that many of us have initiated pale in comparison to the amount of need

that is present. It is essential that there be a careful review of priorities within the VHA for the allocation of budgetary dollars and that thoughtful consideration be given to the needs of VA mental health services. It is particularly important in planning for national health care reform and in planning for veterans' health care that VA reduce the redundancy of expensive tertiary medical care and appropriately distribute funding for the care of the chronically mentally ill.

Thank you very much.

Mr. ROWLAND. Thank you very much, Dr. Falcon.

Mr. ROWLAND. Dr. Lipkin.

STATEMENT OF JOHN O. LIPKIN, M.D.

Dr. LIPKIN. Good morning. I apologize for my voice.

Members of the committee, I am Dr. John Lipkin, chief of staff at the Perry Point VA Medical Center and clinical professor of psychiatry at the University of Maryland School of Medicine. Since 1970, I have been directly involved in acute and long-term psychiatric care, first at Bethesda Naval Hospital, then at the Portland, Oregon VA, the Central Office of the VA, and for the past 7 years at Perry Point.

The provision of treatment for people with long-term mental illness has frustrated the efforts of communities and governments for centuries. People who act strangely but appear able-bodied have been at the bottom of the priority list whenever resources were distributed for their care.

Last year, Congress enacted the Americans With Disabilities legislation which requires better response to many disabilities. Some of the needs of patients with long-term mental illness are so basic that they have been too often overlooked. They include safe shelter, adequate professional services, and the opportunity to work and live as independently as possible. Long-term psychiatric care in the VA attempts to address these elements.

For a person who cannot correctly interpret conversations, noises or sights, being in the hospital may be essential to survival. Quality hospital-based long-term care seeks to prepare as many patients as possible for discharge and also seeks the highest possible level of independence within a hospital setting for those patients who cannot manage outside of the hospital.

For those patients who can return to the community, and that should be most of them, an ongoing framework of services pertinent to their needs often helps prevent frequent readmission to the hospital. These services should not be, as they currently are, primarily provided by the 30 to 40 largely rural facilities that Dr. Falcon mentions. These kinds of ongoing services, both hospital and non-hospital services for long-term care should be available in the same communities where the patients live.

Why do patients in Boston, New York, Chicago, Detroit, San Francisco, et cetera, get transferred elsewhere to places like Perry Point for long-term psychiatric care? I believe that the answer lies in a number of things. One of them is that psychiatric care suffers from the same fashions that influence the rest of society. Long-term psychiatric care has never been fashionable.

The large psychiatric hospitals run by individual States were never adequately funded. In order to improve the care provided to patients in those inadequate facilities plans were developed to move the patients into the community—the deinstitutionalization movement—and to provide the needed services in the community to care for them. With some exceptions, the patients were moved but the dollars were not. As a result, we began to see huge increases in the homeless mentally ill on the streets and in the jails.

Although the VA has not abandoned our patients, we have often failed to provide them enough services in the right places at the right times. Some of this has been Congress' responsibility because of budget issues and eligibility issues which need resolution; that is, some of our most needy patients may not be highly eligible for services until they are in terrible shape, until they are emergencies, particularly in areas where nonservice-connected veterans have been limited in their access.

Some of it has been the VA's fault too. We have usually put high tech tertiary care ahead of low glamour care for patients who are not going to make miraculous recoveries. Our affiliated medical schools make research and education their first priority. Sometimes there is a conflict between clinical needs of patients in a catchment area and the research or education needs of the schools. These legitimate differences in priority can make a substantial impact on the choices made both locally and nationally.

For example, a medical center may have to choose between increasing its capacity to treat cancer or increasing its capacity to treat schizophrenia. The choice is often the result of a mixture of local power politics, intellectual resources and other resources.

From the long-term care hospital's perspective, the difficult struggle to transfer a patient who needs tertiary care, which is not available, for example, at a Perry Point, is the most distressing example about how these resource allocation decisions are made difficult. It is terribly difficult sometimes to transfer a patient for cardiac surgery to any of the tertiary care hospitals around us because they don't much want to take care of long-term mentally ill people with heart disease.

Although there have been some areas of progress, such as the long-term mental health project and the PTSD programs, the VA has been reducing its psychiatric inpatient capacity for over 25 years. In my personal opinion, we have too few psychiatric inpatient beds, and those that we have are generally poorly staffed.

At Perry Point we regularly accept difficult patients from hospitals with better staffing, and yet we too have had to decrease our operating beds in order to improve quality. As we have all noted, the patients that we are seeing are aging. They require more complex medical and surgical care. In order to take care of them at our hospital, we have had to invest in additional medical support. I believe that there are no easy choices ahead.

The patients I see need the sophisticated tertiary care provided in our urban medical cares and they also need a better staffed, more balanced approach to their long-term care. If the improvements needed for this very large group of patients, many of them service-connected, can only be found by taking money from other functions, then perhaps it is time for us to do that. This issue has

been unresolved for my entire career in the VA and I think that is probably a sufficient period of time.

Thank you for your attention.

Mr. ROWLAND. Thank you very much, Dr. Lipkin.

Mr. ROWLAND. Dr. Talbott.

STATEMENT OF JOHN A. TALBOTT, M.D.

Dr. TALBOTT. Thank you very much, Mr. Chairman. It is a pleasure to be here. I am John Talbott, professor and chairman of the Department of Psychiatry at the University of Maryland. I am a Vietnam veteran, and I am also the past president of the American Psychiatric Association, which represents 38,000 psychiatrists in the country.

My work throughout my life has been on the chronically mentally ill. I have written or edited over 120 books and publications and chaired President Carter's special study on the Chronically Mentally Ill, as well as chaired the first American Psychiatric Association committee on that subject.

I have a formal prepared statement, which I would like entered into the record.

Mr. ROWLAND. Yes. Without objection.

Dr. TALBOTT. Thank you, sir. I think you know a good deal about this population. Let me emphasize a couple of points. These are people who suffer from either episodic or continuing severe brain diseases, such as schizophrenia and manic depressive disorder. These diseases render them unable to work, to have adequate family lives, to even carry out the personal things that we take very much for granted—personal hygiene, preparing nutritious food, living well, social interaction, and so forth. They range in range from children to the aged, and as Dr. Falcon has pointed out, these diseases, because they begin in early life, carry with them a life-long sentence of disability.

They live in the community for the most part today, and as you heard before are oftentimes on the streets, subject to the same influences of drugs and alcohol as American citizens in general are. But they also suffer from post-traumatic stress disorder. They also suffer from numerous medical conditions, and the VA population in particular is different in that regard.

Let me address the questions you have asked me to answer. I don't think the VA as a medical system is dealing with this population nationwide adequately. I don't think it has focused its attention on the population as it has on other afflicted veterans groups, as you have heard already. Nor has it been in a leadership position in dealing with the population, despite a number of exemplary programs which you know about and will hear about today.

Now why do I say this? I say it because, with the exception of some individual programs, the VA has really not pioneered in the development of model programs that serve as alternatives to hospital care, to model housing initiatives, and to model systems that track patients while they are in the community and serve as a glue to reduce fragmentation of programs. Likewise, with the exception of some innovators in the VA—you are going to hear from the group from Los Angeles later—the VA has not focused on developing a systemwide focus to the population by developing a contin-

uum of alternatives all the way from halfway houses through supportive living, to independent living; to target the population for application of combined drug and psychosocial intervention coupled with social and vocational rehabilitation; or developed a system of case or care management for every veteran who needs it to help them utilize VA and other governmental benefits and the community services they are entitled to.

What can the VA do? Well, I suggest four points in particular.

First of all, I think—and they are all investments, in my mind, not expenditures. First, it can invest in designing models for the unique populations the VA deals with, for instance, those who have chronic mental illness, as well as substance abuse, PTSD, or who have suffered physical trauma.

Second, it can invest in providing outreach services, such as services for the homeless—a continuum of care, adequate housing and case or care management—for every chronic mentally ill veteran who needs it.

Third, it can invest in a focus on education and training of all professionals who need to work as a team in treating and rehabilitating chronic mentally ill veterans. I might say that the American Psychiatric Association, funded by the Pew Foundation, has conducted such an effort nationwide among our State hospitals and universities, and as Dr. Lipkin pointed out, universities have different priorities. But when you provide them consultations and find out what they wish to do to address a particular area such as the chronic mentally ill you, will redirect their energies in that direction.

And finally, it can invest in a sophisticated effort to measure differences in different VAMCs' efforts through mental health services research. Services research is something the VA has never adequately supported. We all know about the cuts in the general research budget, but services research that measures what services work for which population groups in what settings and their costs, is essential to do, not only for the VA to assess its own operation, but in looking forward to health care reform. The VA is in a particularly strong position to do this, given the number of different facilities using different models which can be measured *in situ.*

It has been mentioned before, but I will mention it again. The VA has had a pivotal influence on many areas in health and mental health, and it needs at this point, whether through a GRECC mechanism or something else, to focus, as it has on PTSD and homeless veterans, on those veterans suffering from chronic mental illness.

This population has been crying out for attention for years. I thank and compliment your committee for addressing it today. Thank you, sir.

Mr. ROWLAND. Thank you very much, Dr. Talbott.

[The prepared statement of Dr. Talbott appears on p. 50.]

Mr. ROWLAND. Let me ask you this. Do you share the view expressed by the National Alliance for the Mentally Ill that VA health care should be moving more in the direction of community-based care?

Dr. TALBOTT. Yes. There is no doubt that the way the majority of people will be best treated is through assertive community treat-

ment through a continuum of care. They will need continuous care teams in the community and they will need adequate housing, because the majority of such people do not need to be in the back wards of 50 to 100 years ago.

And, as Dr. Lipkin points out, the modern VA Medical Center can very adequately provide the focus for that treatment in the individual centers. So I think that we need to move farther along. I think the VA has not moved far enough along.

What I have just said, however, is not true for all patients. There will always need to be some residual, continuing, asylum-type care for 2 or 3 percent of this population. That seems to be a worldwide figure we all agree on. But that still leaves a large percentage who can successfully utilize community care.

Mr. ROWLAND. Do you agree with that, Dr. Lipkin, and Dr. Falcon?

Dr. LIPKIN. I do. I think the numbers are probably right on target that Dr. Talbott mentions. The problem as I see it is that I live in the place that takes care of the 2 or 3 percent part of the times and it is extraordinarily difficult sometimes to turn away referrals from other medical centers because we have no more capacity at our own. Where we sit there is a need for additional capacity for that small group of patients, although I think community care is the desirable model for most patients.

Dr. FALCON. I think that I agree in general. I think one of my big concerns, though, is that under the rubric of community care sometimes there is the ability to ignore patients. It is a lot easier to ignore someone who is living in the community, as we all learned after the well-meaning deinstitutionalization acts of the early 1960s, than it is to ignore someone who is an inpatient in a hospital.

And so I think that as long as there is case management and resources that follow patients into the community and have active community re-entry programs, I firmly support them, with the caveat that we are going to need a core of long-term beds available long into the future. But I think that we must really be very sensitive that the same thing doesn't happen to us that has happened to the State systems in many States where active community support has gone away at the same time that inpatient beds in the State facilities have gone away.

Mr. ROWLAND. Do you envisage this relationship between the VA and community-based being in the private sector or the public sector outside of the VA? How do you envisage that as working?

Dr. FALCON. I think that it could be both ways. Interestingly, in the 14 pilot projects that we are running for this Long-Term Psych Enhancement we have—these are essentially all community-based projects, active community re-entry projects where patients are sought out from the back wards and tried to be brought into the community. I think that one can contract this to agencies, if that is what is appropriate. I think that we also have very aggressive possibilities through readjustment counseling services, through the vet centers. We have community-based assets currently in the VA which we are not using for these types of activities, and I think we should consider using them as well.

Mr. ROWLAND. Dr. Falcon, you have served as chief of staff and the director of the VA Central Region and you oversee more than 40 VA hospitals. Do you believe there is room within this $15.5 billion VA medical care budget to reallocate some priorities to devote more resources to the care of chronically mentally ill veterans?

Dr. FALCON. I absolutely do. I believe that the issues of competing priorities between tertiary medical facilities and tertiary care for medical and surgical cases has to be addressed in the VA. I mean I really think that sometimes we lose sight of who our customers are, that we are here for veteran patients and there is these very complicated relationships with affiliated medical schools, with different residency programs that seem to become overarching concerns.

I think that there is strong possibilities under networks to redirect dollars for the chronically mentally ill.

Mr. ROWLAND. I take it then that you don't think the staffing levels for the mental health program are adequate to ensure timeliness and quality of care for veterans?

Dr. FALCON. No, I don't think so. And I think we see this also on the outpatient basis, as Congresswoman Kaptur was mentioning. The issues of outpatient treatment to prevent rehospitalization are very real out there. We need to be able to control these patients and help them control themselves in the communities better. But in order to do that we really need resources to follow them.

You know, if it is going to be case management, it may be one case manager for 15 or 18 or 20 patients. These are very ill people, and to maintain them in the community is difficult.

Mr. ROWLAND. Is the quality of staffing levels comparable to that in the medical and surgical programs or not?

Dr. FALCON. No.

Mr. ROWLAND. They are not?

Dr. FALCON. No. Interestingly, the staffing for psychiatric services is frequently better in the tertiary facilities that have small psychiatric services, 20 beds or 30 beds, than they are at facilities like Dr. Lipkin's that have several hundred psychiatric beds, and you have disproportionate staffing that works that way. There is a pattern that is consistently inconsistent in the staffing across the country where the sicker patients frequently end up in the places with the worst staffing.

Mr. ROWLAND. Thank you. Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman. I want to commend you for calling this hearing and focusing upon this very critical area.

Dr. Talbott, in your testimony you cited that VA is not doing a good job of taking care of the chronically mentally ill. With that acknowledgment, I am wondering how we compare with State systems? How is the VA doing—is anybody doing a good job in providing for the chronically mentally ill? How does the VA stack up by comparison?

Dr. TALBOTT. That is a very good question and it puts me right on the spot because there is no State that is doing an absolutely splendid job. There are States that are doing better jobs than other States. There are States that have invested more heavily in active good community care, in case management, in housing support,

and there is a nationwide demonstration project going on today funded by the Robert Wood Johnson Foundation looking at 9 cities that have tried to focus on the chronic mentally ill.

The lessons from those cities, as large as Philadelphia and as small as Austin, TX, show that if you focus on the chronic mentally ill, combine the dollars and use capitation, case management and housing, that you do a very much better job.

So we have some beacons that show the way. But I think I would be distorting the record if I said that there was an example in one State that was really wonderful and no one fell through the cracks.

Mr. HUTCHINSON. So we do not necessarily have a model right now?

Dr. TALBOTT. Right. But the VA, because it represents a nationwide system, represents a model for health care reform. I think we have a real opportunity to use that opportunity.

And yes, there are many areas of the country where there are exemplary programs as there are in the VA, but they tend to be scattered and one doesn't tend to see an entire State, an entire region, that really has done an exemplary job.

Mr. HUTCHINSON. How important is integration of medical services with mental health services, and how effective has the VA system been in the integration of those services?

Dr. TALBOTT. It is terribly important that medical and surgical services and psychiatric services be coordinated. Because of the comorbidity of medical problems, people with chronic mental illness tend to have chronic medical illness. We are seeing sicker patients across the board, and in the VA, as you know, the population is older than the population of the general public, so in the VA we have to have even tighter coordination.

You can't have a separate system. You can't, as Dr. Lipkin described it, go shopping around trying to find adequate medical and surgical care. That has to be integrated into it.

I cannot give you an answer to how good a job the VA itself is doing. I suspect that varies. But Dr. Falcon may know.

Dr. FALCON. Well, I think that it does vary. But certainly the mix of medical and psychiatric illnesses, particularly in the post-Vietnam or pre-Vietnam War veteran, is tremendous. Very few of our long-term patients who have primarily mental illnesses don't also have a major physical illness, and we have directed medical/surgical activities to support them.

One point that Dr. Lipkin brought up which we have recently got some information on is the tremendous difficulty that the long-term psych facilities face when transferring these patients to institutions to provide tertiary care, where over half of the physicians surveyed said that they have substantial difficulty in arranging transfer of these psych patients to a place where they are going to get the necessary medical care to back them up.

So we have some systemwide integration issues that we have to deal with. That not only integrating within a facility itself, but also integrating the medical and psychiatric care within a network of hospitals, I think we have to pay more attention and have more accountability for this medical/psychiatric integration.

Mr. HUTCHINSON. Okay. When we think about national health care reform, and understanding that we don't know exactly what

is going to happen, at least I am not privy to it, how do you anticipate national health care reform impacting the VA in the area of mental health care services. Will it increase the demand for the VA's mental health care? Is the VA prepared to handle that if that is the case?

Dr. FALCON. Well, I think that it will increase the demand for mental health care. I think that there is going to be tremendous competition for the tertiary care part. That the number of open heart sites in the private sector competing with open heart sites in the VA sector is tremendous. We don't have a lot of competition in the long-term pysch area. I mean people generally have not wanted these patients. That is why the 50 percent market share acquisition that was mentioned earlier, 50 percent of the veterans that need these services already get them there. Well, they get them there because we provide them.

So I think that the future of these mental health services is clearly going to be called upon in health care reform, and we are clearly going to have a major role in this part of it.

Mr. HUTCHINSON. And is the VA prepared?

Dr. FALCON. Well, I think that we could——

Mr. HUTCHINSON. I see heads shaking.

Dr. FALCON. We could get better prepared. Yes, I think we could get better prepared.

Dr. LIPKIN. If we are going to experience national health care reform, and in growing demand at existing functional levels, that will not be good preparation. We need to be able to do a better job.

Mr. HUTCHINSON. Mr. Chairman, could I ask one more question. I know my time is up.

A 1992 report by the Council on Graduate Medical Education noted that in contrast to the late 1960s when 10 percent of medical students chose psychiatric residency, in 1991 the number dropped to 4.5 and in 1992 to 3.7.

Is this happening, I guess, first of all? And what kind of implications does that have on the VA?

Dr. FALCON. I would be glad to address that, sir. It is clear that people are going into the surgical specialties and not going into primary care specialties such as psychiatry, family medicine and medicine. The clearest reason for that has to do with the financial incentive after a huge loan burden that many medical students acquire.

The pool of people going into psychiatry in the last 2 years has dropped almost 150 persons. Same number of people going into medicine. Same number of people going into training. But our share of that has radically reduced. That has meant that only 22 programs across the country have completely matched their requirements in the last 2 years, and I think it is largely because of the pull and the money and the status of the surgical specialties.

And I think some correction is trying to be undertaken by most States in advance of health care reform, but it is still something that needs to be addressed, especially since most health care reform in the States is addressing family medicine, not psychiatry, which is a critical area. We frequently provide the primary care for many people in places like Dr. Lipkin's facility, in inner-city facilities, in rural areas.

Mr. HUTCHINSON. If it is not addressed, the great disparity between increased demand and fewer providers is just going to exacerbate the whole problem. So that needs to be addressed.

Thank you, Mr. Chairman.

Dr. FALCON. Could I make one comment on that, Mr. Chairman, because I think it is really germane to this issue? That as we look at—we don't want to end up supporting more surgical subspecialty activities within the VA because we add to the problem. You know, the tail wags the dog with this thing. I don't think sometimes this is being looked at from the standpoint of what the patients need, but has to do with what the culture needs.

I really feel that this is a very critical question that the physician pay reform in the VA to a large extent helped to deal with, but it is going to be out there as long as we have this lack of refined appropriations within the VA.

Mr. ROWLAND. Thank you very much. I want to thank all of you.

We have some additional questions which we will submit for the record. We are very appreciative of you being here this morning.

Mr. ROWLAND. Our next panel will be Dr. Jerome V. Vaccaro, who is the chief of Community and Rehabilitative Psychiatry, VA Medical Center, West Los Angeles, CA; Ms. Bonnie Riley, program coordinator, Continuous Supported Self-Care Program at the VA Medical Center in Topeka, KS; and Dr. Ira Katz, director, section on geriatric psychiatry at the VA Medical Center in Philadelphia, PA.

Thank you for being here. And we would ask you to limit your presentation to 5 minutes and your formal statement will be made a part of the record.

Dr. Vaccaro, if you will proceed first.

STATEMENTS OF JEROME V. VACCARO, M.D., CHIEF, COMMUNITY AND REHABILITATIVE PSYCHIATRY, VA MEDICAL CENTER, WEST LOS ANGELES, CA; BONNIE RILEY, M.S.W., PROGRAM COORDINATOR, CONTINUOUS SUPPORTED SELF—CARE PROGRAM, VA MEDICAL CENTER, TOPEKA, KS; IRA R. KATZ, M.D., PH.D., DIRECTOR, SECTION ON GERIATRIC PSYCHIATRY, VA MEDICAL CENTER, PHILADELPHIA, PA

STATEMENT OF JEROME V. VACCARO, M.D.

Dr. VACCARO. Mr. Chairman, committee members, thank you very much for inviting me here today. Thank you too for your concern and attention to individuals who suffer from serious mental illnesses.

My name is Jerome Vaccaro. I am a psychiatrist with expertise in the fields of community psychiatry and care of the chronically mentally ill, and particularly psychiatric rehabilitation. I have spent my career in public service in various county and State facilities, and now in the Veterans Affairs Department at its West Los Angeles VA Medical Center, where I am the director of Community and Rehabilitative Psychiatry, which provides a comprehensive array of rehabilitative services to mentally ill veterans. I also direct training and a clinic at UCLA which is devoted to the treatment of individuals with schizophrenia and other serious mental illnesses.

In my testimony today, I want to describe some of my own experiences and suggest some principles for you to guide decision-making about the design and implementation of clinical programs for the chronically mentally ill. In brief, I will suggest that individuals with these illnesses are both treatable and can be rehabilitated. However, in order to accomplish this our systems of care, as you have been hearing today, need to be better organized and coordinated, need to offer comprehensive services, and also stress reentry into the community rather than maintenance in costly hospitals. And, as you know, cost efficiency really needs to be a paramount concern in anything that we do.

I thought I would first illustrate my points by telling you about a patient with whom I have worked over the last several years. His name is John. John is a 44-year-old Vietnam veteran who served with distinction in Vietnam. His onset of chronic mental illness occurred in his late teens, but he initially, partly because the symptoms were mild and partly for other reasons that I will describe, kept his symptoms to himself. The mild symptoms included things like sleep disturbance, poor attention and concentration, and some social isolation. The other reason for his keeping those things to himself was that his grandfather had been institutionalized for most of his life, and in fact died in a long-term care hospital at an old age, and his brother currently is hospitalized in a State hospital here in the East.

After a period of time, the core symptoms of John's illness included symptoms such as auditory hallucinations or hearing voices, paranoid delusions, and some others. He was able, again, to keep these symptoms to himself throughout his tour of duty, and was ultimately honorably discharged from the military, at which point he went to live with his family, was married and had 2 children, and eventually obtained a job with the telephone company where he worked for some 8 years.

Over the course of time his symptoms became worse and eventually impaired him to such an extent that he lost his job. Next occurred a cascade of events in which his life unraveled. He became divorced. He was unemployed. He ended up homeless, and eventually was jailed for vagrancy. While in the jail he was lucky enough to be recognized as mentally ill and was transferred to a VA Medical Center where for the first 4 or 5 years of his treatment experience he remained on the East Coast.

During this course of time he experienced a system of care which evidenced, really, little coordination between inpatient and outpatient services. He was hospitalized over 30 times during this 4 or 5 years, and in fact spent better than 50 or 60 percent of his time in the hospital rather than in the community.

He particularly didn't like the care he received, partly because of its poor coordination, but the thing that he identified as most problematic was the like of attention to his vocational aspirations—his desire to go back and get a job rather than remain disabled.

In 1989 he moved to Los Angeles and entered the VA Medical Center there where he again experienced some of the poor coordination that I have indicated earlier, but eventually made his way into our compensated work therapy program, which I can describe later if you are interested. But it is a rehabilitation program aimed

to help patients re-enter employment settings. At that point his care was better coordinated through the use of a continuous treatment team that you have heard described earlier today, and to cut to the chase basically, John over the course of the 4 years has not been rehospitalized, now works part time in our compensated work therapy program and part time in a competitive employment situation in the community, and talks about having greatly enhanced quality of life.

John's story is fairly typical of an individual with chronic mental illness; that is, his symptom picture is fairly typical, the pattern of long periods of treatment noncompliance, and long periods of repeated hospitalization are all fairly typical of many patients with these illnesses. And, as you have heard earlier today, a look at the numbers with regard to those afflicted, the economic and social burden placed on our patients and on society is really staggering.

His outcome, though, is also typical—his eventual outcome, that is—of someone who has successfully engaged in treatment and has had access to comprehensive rehabilitative services.

So what can be done? I think first for the VA and for other treatment settings a critical element or a critical thing that needs to be done is that we need to adopt or further expand rehabilitation of the chronically mentally ill as the driving force in our care systems. This means or translates into, first, a decreasing importance of long-term hospitalization and a decreasing importance of hospitals as the base of our care; an increasing importance of the comprehensive continuums of service, community-based care that you have heard described earlier today and that we can expand on later; and finally, an adoption or a dissemination or expansion of certain technologies that we have developed at our VA Medical Center and at some others, things such as social skills training to help people learn social and independent living skills, vocational rehabilitation, the compensated work therapy you have heard me refer to, incentive therapy, another unique VA program, supported employment, which is a program wherein patients are helped to get jobs and keep jobs, and transitional employment, which is another program where patients are placed in employment settings and supported in those settings; finally, case management needs to be included, as Dr. Talbott indicated—all in the context of a continuous and comprehensive array of services.

We also need to focus on and adapt some of these technologies to the special populations you heard mentioned earlier—the homeless mentally ill, we have recently mounted a comprehensive homeless effort in Los Angeles to attempt to do this; substance abusing mentally ill individuals; individuals who have other forms of mental illness and PTSD; and the geriatric population as well.

Finally, just a point about research. I think it is really important as we change our systems of care and focus on some of these issues that I have mentioned that we stress outcome evaluation, which basically means that we need to invest our research resources in the mental health services research arena. We need to be looking at our interventions and asking questions such as, Do they decrease relapse and rehospitalization? Do they increase vocational and work outcomes? And do they ultimately increase the quality of life of our patients?

I will end there, and if there are any questions or comments later on, I would be happy to answer those. Thank you.

Mr. KREIDLER [presiding]. Thank you, Dr. Vaccaro.

[The prepared statement of Dr. Vaccaro appears on p. 56.]

Mr. KREIDLER. Ms. Riley.

STATEMENT OF BONNIE RILEY

Ms. RILEY. My name is Bonnie Riley. I am a social worker at the Colmery-O'Neil VA Medical Center in Topeka, KS. I am the coordinator for a psychiatric case management program called the Continuous Supported Self-Care Program. In my 13 years with the VA, I have worked in inpatient psychiatry, day treatment, residential care, group living, and psychiatric nursing home consultation.

CSS–CP is a community-based rehabilitation program for veterans who experience severe and persistent mental illness. Clinical case managers assist the veteran patients in their transition from the psychiatric inpatient ward and in their ongoing integration into the community.

With CSS–CP support, the first 25 veterans discharged to the community experienced an 85 percent reduction in their rate of hospitalization. This accounted for 5091 fewer days of hospital care.

Improved quality of life is an even more important aspect of community-based psychiatric rehabilitation. Michael Sheer entered the CSS–CP program following 6 years of psychiatric illness, which included 2 years of hospitalization for schizophrenia, substance abuse, suicidal behavior, chronic depression, homelessness, and unemployment. Mike will speak to the impact that CSS–CP has made in his rehabilitation and successful community living.

[Video presentation.]

Mr. KREIDLER. Thank you very much. That was very moving.

[The prepared statement of Ms. Riley, with attachment, appears on p. 65.]

Mr. KREIDLER. Mr. Katz.

STATEMENT OF IRA R. KATZ, M.D., PH.D.

Dr. KATZ. I am Ira Katz from the Philadelphia VA Medical Center and the University of Pennsylvania.

It is a critical time for the VA to be reevaluating the mental health care of elderly veterans. By the year 2000 there will be more than 9 millions over age 65 who will constitute almost two-thirds of America's men in this age group. At that time World War II veterans will be among the old old, when the majority have chronic disease causing disability and when the incidence of Alzheimer's disease is highest.

There are three groups of elderly patients with chronic mental illness, each with its own needs. Most apparent are those elderly patients whose psychiatric disorders began earlier in life. Their needs don't remain static. Needs change because some patients with schizophrenia exhibit improvements as they age with new possibilities for rehabilitation and recovery. Also, as patients age, so do those in their families who provide support, so that it may be necessary to modify the patient's care at times by providing respite services or residential care, depending upon what happens to family care-givers.

Finally, there are problems related to the development of medical illnesses. As the veteran population grows older, maintaining chronic psychiatric patients in the community will increasingly require general medical as well as psychiatric services. For patients with chronic mental illness, psychiatry is best conceptualized as the primary care discipline and psychiatry departments should be provided with resources to deliver basic primary medical care.

A second group of patients are those with Alzheimer's disease and related disorders. Although new drugs are under development and a significant body of research is in progress, the VA should not place itself in a position of waiting for a breakthrough. While treatments are not available to prevent or cure Alzheimer's disease, established clinical interventions can have profound benefits by searching for reversible sources of disability and by treating symptoms such as depression, hallucinations, delusions, and agitation.

In addition, programs that provide support for care-givers as well as direct care for the patient can delay nursing home placement and save costs while maintaining patients within the community. Thus, current knowledge warrants establishing programs for Alzheimer's patients in all VA facilities.

A third group of patients are those with chronic disabling medical illnesses complicated by psychiatric disorders, primarily depression. The majority of elderly patients with depression are never seen by mental health professionals and experience chronic mental illnesses only because potentially reversible disorders are not recognized or treated. Major depression is approximately 10 times more common among nursing home residents than the community elderly.

Although these depressions may make sense, they are in fact illnesses and ones that remain responsive to psychiatric treatment. The nursing home, moreover, is only the tip of the iceberg. Depression is frequently associated with each of the common chronic illnesses of late life, and untreated is a cause of excess disability and increased utilization of health care services.

To summarize, VA facilities should have programs in geriatric psychiatry that include both specialized units as well as mechanisms designed to bring geriatric psychiatry to general medical services. Mental health clinics should provide primary medical care and case management as well as psychiatric treatment for chronic patients grown old. They can also serve a primary care function for patients with Alzheimer's disease.

In addition, geropsychiatry programs should extend beyond traditional psychiatric settings. The large majority of elderly nursing home residents have psychiatric disorders, primarily dementias or depressions associated with medical illness, but few nursing homes are staffed or organized to care for them appropriately. Moreover, the nursing home is just one example. Geropsychiatric consultation and treatment teams functioning across medical care settings can have a major impact by reducing distress, excess disability, and excess health care costs for elderly veterans with chronic illnesses.

Thank you.

Mr. KREIDLER. Thank you very much, Dr. Katz.

[The prepared statement of Dr. Katz appears on p. 68.]

Mr. KREIDLER. This is a very interesting presentation. My mother worked at American Lake Veterans Hospital, starting from about 1940, which, of course, up until she retired was a psychiatric VA hospital at American Lake. In fact, when I was a psychology undergraduate major and did several case studies—based on being able to keep, of course, identities private and confidential, but I did several studies and dealt not a little bit with the chronically mentally ill and trying to deal with their problems.

Dr. Vaccaro, you mentioned the compensated work therapy program. American Lake happens to have a program like that I had an opportunity to visit, and I was wondering if you could give any indication from your experience at your facility, which I had a chance to visit. When I was earning a master's in public health, we spent some time over at West LA VA facility. I was wondering if you could just give some indication from your mentally ill population how many would benefit from a program like this?

Dr. VACCARO. From compensated work therapy specifically?

Mr. KREIDLER. Correct.

Dr. VACCARO. Well, our compensated work therapy program serves about 120 patients on any given day, meaning there are anywhere from 100 to 120 patients working at some meaningful productive activity and being compensated for that. We never have an open slot for more than a few days. So that speaks to, I think, the demand for our services.

In my experience as a psychiatrist, I don't think I have ever met a patient who hasn't said to me that one thing they would like to do is return to work. So in terms of its impact, its importance, in most cases I would say it is the critical issue, and in the case study that I presented today the vocational rehabilitative aspect of his treatment was really the hook that kept him in treatment and that gave him hope.

So I would say virtually everyone has the capacity to engage in some meaningful productive activity for which they can be compensated.

Mr. KREIDLER. Would either of you, Dr. Katz or Ms. Riley, care to respond to that from your perspective at all?

Ms. RILEY. Well, I might add a case study that I think is applicable. We have a veteran named Jim, and one of the most important things in his rehabilitation was paying close attention to his vocational goals. He had a presenting diagnosis of schizophrenia, he giggled inappropriately, he paced up and down the hallways, and his hygiene was very, very poor. He was someone who had been relegated to the back ward, so to speak. We sat down with him and asked him what he wanted most in his life, and he said that he wanted to be an astronaut for NASA.

We didn't discount that. We sat down with him and we tried to figure out those steps that were important in becoming an astronaut for NASA, and we broke them down into tiny components. We also gave him model kits and he built rockets. They were the type of kits, I don't know if you are familiar with them or not, that kids can build that actually launch. We would have recreational outings and Jim would go along and he would launch his rockets. He began to draw the attention of other veteran patients and he became known as the rocket man.

The upshot of all this is that he began to take more pride in himself. He began to feel good about himself because it was something that he could accomplish.

He is now living out in the community in an apartment with two other veterans. He no longer needs to be an astronaut for NASA because he is okay with who he is.

I think it is a testimony to the strengths perspective of case management which we employ in CSS–CP, and I think it is also a testimony as to what motivates clients to do well. Quite frequently, Dr. Vaccaro is correct, it is vocational goals and aspirations that are very, very important.

Dr. KATZ. Care of patients with early Alzheimer's is a major challenge. They often fall in the cracks between programs for senior citizens in the community and those programs that exist for daycare of more severe patients. There have been pilot studies of compensated work programs for early Alzheimer's patients. One of them at the Minneapolis VA GRECC has really shon wa good deal of promise in this area.

Mr. KREIDLER. Thank you very much. I wish we had a little bit more time. We are coming up on a roll call vote here, as you can hear the bells and whistles going off here. But thank you very much for your testimony today.

And if our next panel would be kind enough to come forward. As you are kind of getting settled there, and, Dr. Farrar, I am looking forward to hearing your comments, I am going to, regrettably, have to recess the committee in order to run over and cast that vote, and I will be back as soon as I possibly can.

[Recess.]

Mr. KREIDLER. I apologize. There were three votes and the final passage vote that delayed us in proceeding with this hearing.

Dr. Farrar, if you would be kind enough to start.

STATEMENT OF JOHN T. FARRAR, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CHARLES A. MILBRANDT, ACTING ASSOCIATE CHIEF MEDICAL DIRECTOR FOR RESOURCES MANAGEMENT; SANFORD M. GARFUNKEL, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR OPERATIONS; PAUL ERRERA, M.D., DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; WILLIAM VAN STONE, M.D., CHIEF, TREATMENT SERVICES DIVISION, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; JOAN SHELDON, M.S.W., DEPUTY ASSISTANT DIRECTOR FOR REHABILITATION, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE, VA MEDICAL CENTER, HAMPTON, VA

Dr. FARRAR. Thank you very much, Mr. Chairman. I am John Farrar. I am the Deputy Under Secretary for Health of the VA. Thank you very much for scheduling this hearing to review the VA care of veterans suffering from chronic mental illness. This is a very important issue to all of us in the VA.

With me today are Dr. Paul Errera, on my right, Director, Mental Health and Behavioral Sciences Services; Charles Milbrandt, Acting Associate Chief Medical Director for Resources Management; Mr. Sandy Garfunkel, on my left, Associate Chief Medical

Director for Operations; Dr. William Van Stone, Chief, Treatment Services Division of our Mental Health and Behavioral Sciences Services; and Ms. Joan Sheldon, Deputy Assistant Director for Rehabilitation Services of Mental Health and Behavioral Sciences Services.

Mr. Chairman, in the interest of time I would like to enter my statement in the record and just make a brief statement before I entertain questions from you.

Many important points have been made in this hearing, and I believe that we as a system must address these issues promptly. As to medical care, we will devote the next planning meeting of VHA, it will be either in July or August, to review specific ways in which we can improve the care of the chronic mentally ill.

As to research, I agree that more research funds should be directed to chronic mental illness. It is of interest that the recent HSR&D research meeting was completely devoted to mental health research. If research funds for 1994 are in the $248 to $252 million range, I believe that we should consider research proposals directed to the care of this important group.

So I would say VHA will review both medical care appropriations and research and attempt to deal with these important problems.

We would be delighted to respond to questions, and there may be others that may wish to make statements. Thank you very much.

[The prepared statement of Dr. Farrar appears on p. 78.]

Mr. KREIDLER. Thank you very much, Doctor. Would others offer comments at this point?

[No response.]

Mr. KREIDLER. I was wondering, Doctor Errera, do you share the view of some of the witnesses that changes are needed in the way VA funds and provides mental health care services? And if so, what is your prescription for change?

Dr. ERRERA. Yes, I do, sir, Mr. Chairman. I do agree with the witnesses.

Traditionally, mental health in any health system has been at the bottom of the totem pole. This is not just the VA. It is true for the State hospital system. It has always been underfunded and presently is getting even lower funding.

My concern is that I don't think that health professionals are willing to change that. So to the degree that health professionals control the delivery of health care and its funding, they will put the money where their interests are.

The only way that in the last 9 years I have been able to expand programs has been new monies that came from the executive branch, from HUD, from HHS, from the War on Drugs, or from Congress. So I welcome what Dr. Farrar just said. I am sorry that his term is limited when I hear these kinds of words. And I am not confident in my bones that VHA would implement what he recommends.

Mr. KREIDLER. How many years have you been now with VA?

Dr. ERRERA. I have been with VA since 1954, sir, but I have been in Central Office for the last 8½ years.

Mr. KREIDLER. Is it fairly representative of what has happened just with mental health outside the VA system as to what you have seen in the VA system over this period of time?

Dr. ERRERA. I would say we have done a little bit better in the VA. Again, the comparable system is the State system for people who are not rich. If you are rich, you get very good care—for the rich, the very rich, and the very, very rich. Before everybody else, the State hospital system is a very bad system. And our system, as was described earlier this morning, has some very bad and some very good. We have a real continuum of different levels of care and quality of care.

So I wouldn't say we are worse than the State hospital system, but we haven't done that much better. The thing that is tragic for people like me is that it is not like AIDS where we don't know what to do because we don't have the cure. In mental health, as you heard this morning, we do know what to do. We just don't have the resources.

Mr. KREIDLER. Is it partly because of medications and what has happened with the deinstitutionalization that took place starting in the 1960s that you have seen somewhat of a paralleling with the VA system, that even though it may have done better than the States on average at the same time the shift that took place has been virtually the same sort of shifting taking place in the VA system?

Dr. ERRERA. There has been a kind of deinstitutionalization in the VA. But we still have a workload of a third to 40 percent.

Mr. KREIDLER. Right.

Dr. ERRERA. While the funding is at 10 percent. That says it all. So that we know, for example, when we discharge somebody—we heard this morning somebody was readmitted 17 times. Well, one of the reasons that happens is because the person doesn't get the discharge care that they need in terms of case management, helping them find work, putting them in a residential place where we can work with them. The kind of thing Ms. Sheldon is now doing with subpopulations of alcoholics, substance abusers and homeless. We could be doing that with the chronically mentally ill that are in our hospitals but we don't have the capacity to do it.

Mr. KREIDLER. Very good. How do you explain the variability, Dr. Farrar, on our per patient expenditures for the chronically mentally ill from hospital to hospital? I mean how do we get this kind of variability on a patient by patient basis?

Dr. FARRAR. Well, let me ask Mr. Garfunkel to respond that. He is our man in terms of operations.

Sandy, would you?

Mr. GARFUNKEL. Sure. I don't have the figures that you have, Congressman, but we find nationwide variability in almost every category of care that we give. I think that is pretty consistent with what is found in the private sector as well. We take a look at figures when we do RPM models and our resource allocation models. We take high outliers and low outliers and try to even out the playing field a little bit. Obviously, different medical centers provide different amounts of resources for different categories of illnesses.

When we look at what is happening in the private sector as far as allocation of resources, we think that we are somewhat consist-

ent with the various models that are used and how we do it, and we really can't explain every individual variation but we certainly take a look again at the outliers, both high and low, and try to make adjustments so that those variations will change.

Mr. KREIDLER. And certainly patients should have the expectation that if they happen to be in one VA facility or another that there is going to be—they can expect the same level of treatment and so forth within that particular facility's, obviously, allocation of resources and so forth? I mean the size and so forth, it would matter. But if they were comparable facilities it should be comparable services, and that should be the expectation of the patient, I presume. Is that correct?

Mr. GARFUNKEL. Yes, sir.

Mr. KREIDLER. Excuse me. Dr. Errera.

Dr. ERRERA. Dr. Lipkin said something I thought important, or maybe it was Dr. Falcon. The tertiary care psychiatry service is more likely to be better funded than the large neuropsychiatric. Yet the more difficult patients are sent to the large neuropsychiatric facilities.

Mr. KREIDLER. You know, maybe I just wasn't close enough to it, but I can remember American Lake being overwhelmingly schizophrenic patients at that time. And of course, then it was essentially phased out as a mental health facility.

I don't know if you ever knew a Dr. Diamond who was head of that facility, chief of psychiatry, I believe, for the facility or medical director. I am not sure of his title. He is somebody who was a family friend and I never knew his professional responsibilities there. He is now retired from the VA system.

Are these a large share of the ones right now that formerly were in a VA hospital like American Lake that now make up the ones that are—that significant share of the 30 percent right now of the hospitalizations that are taking place?

Dr. ERRERA. It certainly could be. The VA did the same thing the rest of the country did in terms of cutting back on psychiatric beds. For example, Northport was like Takoma. It was a large neuropsychiatric facility, and then it became general medical and surgical because that was the thing to do. So they cut back on psychiatric services and expanded surgical and medical, which is what happened in Takoma. That was a trend.

And as a result, the overall capacity to deliver services decreased. But in the days you are talking about, unfortunately, we didn't know enough to focus on community services. We were still focusing primarily in those days on hospital care.

Mr. KREIDLER. Exactly.

Ms. SHELDON. I think also we are getting a lot of younger veterans, especially like the American Lake program. With our programs, the work programs and the housing, our average age is about 40, and these are hardcore veterans who have had very little education, who have had very few support systems and really need the kinds of community supports and programs that we are trying to develop, similar to the American Lake.

Mr. KREIDLER. Ms. Sheldon, would you care to, maybe, elaborate a little bit more about the compensated work program at American Lake and comparable facilities?

Ms. SHELDON. Compensated Work Therapy (CWT) are programs to meet the vocational needs of the younger veteran who has many years of employment remaining. The programs are developed to contract with the Government, and industry in the community for work projects so that veterans can work, earn money to live in the community, develop job skills, and to basically retrain and change their lifestyles.

The CWT organizational structure provides a sheltered work environment on VA grounds similar to the program at American Lake. A second step is Supportive Employment where veterans are placed in employment in the community working with other employees in a company like Boeing Aircraft or any large industry, or the VA. We are encouraging the VA to allow veterans in this program to work more extensively within the medical centers. They can learn skills which will make them employable by VA and industry in general.

Over a period of time veterans are helped to develop skills, work habits, and change behavior so that when they leave the hospital, they will have less need to return to the medical center.

A second program provides transitional houses in the community. Patients have group meetings; pay their own rent and utilities, and purchase and prepare their own food, monitor medications and provide drug screening. They are in treatment programs and must work in CWT as part of their therapy in gaining control over their own lives.

And, as you know, addiction and mental illness, develops over many, many years. You cannot change people's behavior in 2 weeks. It is impossible. This program encourages behavior changes over a period of many months. Meanwhile, veterans are supporting themselves while receiving treatment. Actually, the Government is paying very little of their care at this point.

Mr. KREIDLER. Maybe part of the question is, from the standpoint of just sheer cost is that it is kind of like nursing home care that we face, that there is a tremendous population out there that is receiving care through the informal care system and that when you open the door and begin to have expanded programs like these that there is such a huge number out there that would substantively benefit from a program like this, but if you crack the door you wouldn't have the resources to meet your overall responsibilities? Is that part of the concern?

Maybe, Dr. Farrar, you would be the one to respond to that? Or Dr. Errera?

Dr. FARRAR. Maybe Dr. Errera can respond to that?

Dr. ERRERA. I think it is a social question as to where do we want to put our priorities.

Mr. ROWLAND. They want the mike there, if you could.

Dr. ERRERA. I think it is a question of where do we want to put our priorities, and that is a question which either the health professional decides, or the representatives of the people decides, or we do it together. I know where my vote lies, but that is not necessarily what VHA says.

It is a little bit like the Oregon Plan, you know, what is going to be included and what isn't. Because clearly if I got what I asked for Dr. Farrar would have to take the money from somewhere else.

I would say take it from high tech but he might not want to and other people might not want that.

Mr. KREIDLER. We are clearly looking at a program that if carried out to its fullest extent would take a considerable amount of resources right now that are allocated differently. I presume that is a fair assumption, and only looking at it from a fiscal side rather than looking at it from a human side of what is the best thing and what we should be doing.

Dr. FARRAR. I wouldn't look at it quite that way, Mr. Chairman. I would say that what we need to do is to begin to move this more rapidly toward alternative care in the community, various kind of home care, community-based, outpatient care. We need to move that. We need to plan it and need to get it going faster than it is going, and I think over the next 2 years, maybe 3 years from now we will see a very substantial change, and I would hope we would never come back and have these problems, if at the end of, say, 3 years we can do a very much better job.

My thoughts would be the summer, as we go into the planning process we get from Dr. Van Stone and Dr. Errera and from Joan Sheldon kind of a list of the most important pilots—also, you heard about this from Spencer Falcon—the most important pilots that we are doing, possibly even thinking a little bit for next year about MHREC—that is the Mental Health Research and Education Centers—and start thinking about all of these things and moving them much more rapidly, rather than just sitting around talking about it.

Mr. KREIDLER. What would be the steps—what are kind of the timelines that you are going to be following right now to see this happen or to implement this?

Dr. FARRAR. You know, I really can't—I don't want to get too far out in front of the group, but my thought would be we would start this summer thinking about what are the pilots. I think there are 14 pilots that we are working, various other things, and we ought to get some approval on concept and take some money out of the 1994 budget to do some of these things, begin to get them going and put more money, substantial money into the 1995 budget.

Mr. KREIDLER. Dr. Errera.

Dr. ERRERA. I feel awkward because what Dr. Farrar says sounds like what I have always wanted to hear. But at the same time I look at the way the funding allocations are being made and they don't speak that language.

Mr. KREIDLER. Can I put you on the spot a little bit and just say do you think we need to have legislation to help direct these kind of changes?

Dr. ERRERA. It has never happened without it before. Miracles happen but I certainly don't plan on them. I welcome them when they come.

Mr. GARFUNKEL. Congressman, if I could just comment on the funding allocation. As you probably know, we are in really the first year of a new method for allocating funds. It is a methodology that does give us the capability of reallocating funds towards workloads where we would want the funds to be. I think the methodology this year, even in looking at how it has worked out so far, and the final numbers are not in yet, does show that there is some movement

of funds from some of the, what we call CPGs, or clinical patient groups, which are the acute care medical and surgical groups, now there is some movement away from those groups and some movement into some of the psychiatric groups, although only in a moderate way.

We do have that mechanism, however, to move money and to fund our medical centers based on a planning process that I think Dr. Farrar has indicated he wants to begin. So that capability is there.

Mr. KREIDLER. Dr. Errera, if I might come back to you on the specifics of legislation. What specifically would you recommend?

Dr. ERRERA. I agree with Mr. Garfunkel the mechanisms are there. The problem is the people who decide what mechanisms will be used.

Mr. KREIDLER. And I understand.

Dr. ERRERA. I think if we were told that this is something that has to be done then I am sure Mr. Garfunkel and his people would do it. But I think that if we are not told that it has to be done—let me put it this way. When RAM was introduced mental health lost $40 million in the process. Everybody was very sorry about it. But the money went from the chronically mentally ill, the large neuropsychiatric facilities, and moved to acute medicine and surgery.

I have been accused of being paranoid and I think people are right. I am a little bit paranoid. But I am concerned that this not happen again.

Mr. KREIDLER. Let me come back because I need to pull this together, and if I could, Ms. Sheldon. American Lake is one of, I believe, three facilities that are in a non-profit status. Maybe you can explain, because I really don't understand, why did they wind up being non-profit—and is that an advantage for them to be in a status like that?

Ms. SHELDON. Yes, it is an advantage. In 1976 legislation was passed to give the VA authority to run a Compensated Work Therapy (CWT) program. At the same time Congress said that we could no longer establish non-profit corporations and only those that were currently existing at that time could continue. Since then we have through homeless and substance abuse funds been able to establish additional programs. As a result many programs have expanded. The purpose for non-profit corporations, for which we are very interested in having new legislation, is to expand our capacity to receive grants (both Federal and private) and to utilize non-VA resources from sources such as HUD. We are not eligible to obtain funds outside the VA housing to which private and non-profit agencies have access. A non-profit corporation could provide this access.

American Lake is a non-profit corporation, because they were non-profit prior to the legislation and they were just reinstated. It would be very helpful for all of the other hospitals to have non-profit corporations where we have compensated work therapy programs.

Also, VA is not allowed to contract with NISH, which is a special set-aside contracting program for private industry. If we have a non-profit corporation, we could work with the non-profit to develop NISH contracts. Once established they are extended for years.

Mr. KREIDLER. Good. Sounds like that may take some specific legislation.

Ms. SHELDON. It will take specific legislation. And, of course, we are also interested in raising the cap on the transitional housing which we have been working toward.

Mr. KREIDLER. Very good.

Dr. Rowland.

Mr. ROWLAND. You finish with this panel.

Mr. KREIDLER. Great. I want to thank you very much then for your questions and comments and so forth. I appreciate it very much.

Mr. ROWLAND. I thank Dr. Kreidler very much for helping me with this hearing this morning.

I guess our last panel now is Richard T. Greer, National Alliance for the Mentally Ill; John R. Vitikacs, assistant director, National Veterans Affairs and Rehabilitation Commission of the American Legion; Mr. William Crandell, legislative advocate, Vietnam Veterans of America; Mr. James Magill, director, National Legislative Service, Veterans of Foreign Wars; Mr. Terry Grandison, associate legislative director, Paralyzed Veterans of America; and Charles Prigmore, national junior vice commander, American Ex-Prisoners of War.

And I want to thank all of you very much for your patience this morning. We were caught on the floor for about an hour and a half with a series of votes. That was unavoidable. If there is anything that is certain up here it is uncertainty. So thank you all very much for staying here with us.

If you will limit your remarks to 5 minutes, your entire testimony will be made a part of the record. And we will start with Mr. Greer.

STATEMENTS OF RICHARD T. GREER, NATIONAL ALLIANCE FOR THE MENTALLY ILL; JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; WILLIAM CRANDELL, LEGISLATIVE ADVOCATE, VIETNAM VETERANS OF AMERICA; JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; CHARLES PRIGMORE, PH.D., NATIONAL JUNIOR VICE COMMANDER, AMERICAN EX-PRISONERS OF WAR

STATEMENT OF RICHARD T. GREER

Mr. GREER. Thank you, Mr. Chairman. My name is Richard T. Greer. I am a veteran of World War II, having served with the Army Air Corps, and I have discovered here this morning an old colleague I served with in the same air group in England during World War II.

I have a son who is disabled by mental illness. For a number of years, I was director of government relations for the National Alliance for the Mentally Ill here in Washington. This association is comprised of more than 140,000 member families who have one or more members with severe mental illness, usually schizophrenia,

manic depression or major depression. Since I retired from NAMI a few years ago I have been a volunteer advocate working to improve services for severely mentally ill at the local, State and Federal levels.

In my own State of Virginia, like so many across the Nation, we have got about 70 percent of our resources tied up in our large State hospital facilities with the remaining 30 percent going to our communities for services for adults and children with mental illness. Our challenge is how to shift the resources to the community where 9 out of 10 mentally ill people live. It is now abundantly clear, of course, and we have heard it many times this morning, that mentally ill persons can achieve stability and a better quality of life in the community. Most of them wish to be engaged in the very things that all of us are engaged in: family life, independent living, work and recreation.

And for many this requires support, whether it be support in living independently, using transportation, work and training, or medical care, including emergencies. The problem in our country is that we don't have enough resources at the community level.

A little reality check. We are talking about the VA system, but out there in the world at large in the last 10 years, notwithstanding our advocacy, in the last 10 years our progress in services at the community level has not been much. It has not been much. And the question is largely a resource question because we have the know-how. That is what my advocacy is about, and that is what the National Alliance for the Mentally Ill is all about.

We must persuade America that it is time to invest in these services quickly because it is so much more costly to us all without adequate quality services. It is costly in the overuse of emergency rooms, in jails, in homelessness, in the nonproductivity among those who could work and pay taxes.

There is a new book out called The Nation In Denial: The Truth About Homelessness which, surprisingly, says and documents—it is a very adequately documented book—that from 65 to 85 percent of adult homeless persons have alcoholism, drug abuse or mental illness or a combination of the three. That is a larger number than I think we have been hearing. And the authors are suggesting that the "denial" is to play up the unemployment, the lack of affordable housing, et cetera. The real issue, the major cause of homelessness, is the treatment issue of these people.

As you know, many of these homeless people are veterans. We heard it many times this morning. Many of us in the National Alliance are parents of veterans or we are spouses of veterans or we are siblings of veterans, and so we are deeply—we care a great deal about the quality of care or the lack thereof in the VA health care system. It is our understanding, and I have heard it again this morning, there is a maldistribution within the VA system about the patients you have versus the resources you have compared to other disabilities in your system.

I remember when I was advocating actively with NAMI 5, 6, 7 years ago I heard this same problem. Nothing has changed inside the VA system. And I want to throw my voice in on the side of those that say it is going to take this committee to direct that De-

partment to make these changes. I don't think they are going to do it themselves.

So my plea to this committee is that you use your resources to hasten this change, these cost shifts, and to move more of these people out into the communities. Dare we hold these people in appropriate care settings any longer than they need to be there? If optimum quality care and treatment means integration into community life for most veterans with psychiatric disorders, can this country do less for them?

I said that there are presently inadequate services in most communities, and you might ask why then would you want us to move veterans into these environments? Aren't they better off where they are? And I think the answer is that if we look at what some VA hospitals are already doing, they are forging creative new arrangements with surrounding communities that will benefit and support veterans in communities.

And NAMI families, we are organized in a thousand chapters across this country and are out there actively available for partnerships, for creative kinds of roles. We are involved in communications and boards, in positions of authority at the local level. I am on my Community Services Board where we are able to facilitate a mesh of community services with the VA in creative support environments out there. We know how to do these things. We just have to create them at local levels, I think.

So I would like this committee to appreciate the importance of moving the money with the patient. My formal statement describes the evolution of some successful service treatment models like PACT and so on.

Let me close by repeating that I think it is important that this committee support these approaches, and encourage them and the development of other models through services research.

Thank you very much.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Greer, with attachment, appears on p. 88.]

Mr. ROWLAND. Mr. Vitikacs.

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Good morning, Mr. Chairman, and members of the subcommittee. The American Legion appreciates the opportunity to express its views regarding the care and treatment provided to chronically mentally ill veterans by the Department of Veteran's Affairs.

Based on site visits by Legion field representatives to VA medical facilities, we realize there is a problem with the treatment of the chronically mentally ill veteran. On one hand, VA's homeless chronically mentally ill program has experienced numerous successes, due in large part to positive congressional support, exceptional staff work, and appropriate funding support.

It is interesting to note that a chronically mentally ill veteran can receive more comprehensive care and treatment when they are homeless rather than receiving appropriate care prior to their becoming homeless.

Mr. Chairman, the reasons for the dispiriting state of care provided to chronic psychiatric patients today in VA are many. Undoubtedly, some medical centers have much more success than others in regard to the treatment of chronic psychiatric patients. Through site visits to VA medical facilities around the country, Legion field representatives report problems associated with the lack of long-term care resources and referral or alternatives for chronic psychiatric patients and concerns about the engrained poor attitude about treating chronically mentally ill patients. It simply is not a glamorous practice.

As noted in our written statement, most Legion field service visits to all types of VA Medical Centers report increasing problems about the current state of chronic psychiatric care in VA. There is an increasing number of psychogeriatric patients in VA who require long-term care. With their associated behavioral problems, the older psychiatric patient has less community placement alternatives and therefore increasingly occupies nursing home or other long-term care beds, making it much more difficult for VA long-term care facilities to fulfill their missions as psychiatric referral centers.

Frequently bed shortages have caused the inappropriate placement or retention of chronic patients on the wards. It also has limited access to care for new patients or patients needing readmission for acute care and require the initiation of a waiting list for extended care psychiatric patients.

Mr. Chairman, the earlier the intervention in the treatment of certain mental illnesses the better the chance there is for a successful treatment outcome. The Legion believes the described problems will only become worse if effective solutions are not soon forthcoming. Eligibility changes to make outpatient mental health care more accessible are necessary. More emphasis and resources need to be focused on the care and treatment of the chronic long-term care mentally ill veteran and a structured rehabilitation program focusing on the quality and quantity of care required for successful re-entry to a residential community setting should be the treatment goal for this difficult-to-treat group of patients.

Also, a greater focus on health services mental health research is necessary to understand what treatment works best, and the American Legion supports the development and funding of previously proposed mental illness research, education and clinical treatment centers, also known as MRECCs.

Lastly, we believe that an integrated systems approach along with increased research efforts to care for and treat chronically mentally ill patients is required.

Mr. Chairman, that concludes our statement.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Vitikacs appears on p. 82.]

Mr. ROWLAND. Mr. Crandell.

STATEMENT OF WILLIAM CRANDELL

Mr. CRANDELL. Thank you, Mr. Chairman. Vietnam Veterans of America welcomes this opportunity to discuss VA care of the chronically mentally ill and alternatives to long-term care. The staggering costs of long-term care in mental health reach far beyond the

damage they do to budgets. Veterans who find no help short of long-term care suffer terribly, as do their families.

Post-traumatic stress disorder, PTSD, is a major contributor to chronic mental illness among veterans. It is a chronic disorder in itself, not limited to Vietnam veterans but attacking those who served in every war. The VA has done little of its own accord to address the magnitude of the PTSD epidemic. Veterans with PTSD who are treated in VA general psychology or psychiatry inpatient, outpatient or other clinics must be treated for the proper disorder. Today, no such guarantee of proper treatment exists.

Far too frequently the VA looks at PTSD and sees instead only the substance abuse that is so often a telltale symptom of PTSD, branding the symptom willful misconduct and refusing to diagnose the disorder itself. And the notion that PTSD where it is detected is not service-connected but merely the outgrowth of some hypothetical childhood instability is still too prevalent in a veteran's health care system that has seen veterans return from war for half a century with these symptoms.

The VA is only beginning to recognize that women can be affected by PTSD too. Congress must adopt legislation recognizing the aftermath of sexual trauma as service-connected post-traumatic stress disorder. As more women flow into the military, they have already begun swelling the ranks of veterans with service-connected stress problems. VA's general unreadiness to accommodate women patients in the VAMCs is reflected in psychiatric facilities as well.

The best alternatives to long-term care for chronic mental illness related to PTSD and other major mental illnesses are early treatment and outpatient care. For many 100 percent disabled veterans full-time institutionalization is neither necessary nor desirable. They may be in and out of VA facilities, going in when the stress of their daily lives compounds their problems and in intervals living fairly normal lives after periods of treatment. The Vet Center program operated by VA's Readjustment Counseling Service has done remarkably successful work over time to keep veterans out of long-term institutional care for PTSD.

The need for the Vet Centers have increased since the war in the Persian Gulf. Some 28 percent of the cases involve seeing dead bodies and 15 percent derive from fears of SCUD missile attacks. These stresses do not involve only front line troops. The potential for a massive influx of Desert Shield/Desert Storm veterans of PTSD is serious. Early treatment through the Vet Centers can keep most of these cases from becoming serious.

Early treatment of PTSD requires both an expansion of the Vet Center program and recognition by Congress and the VA that RCS is not a temporary administrative structure. We are seriously interested in legislation that is currently being drafted under the title Readjustment Counseling Service Amendments of 1993, which will further these aims.

Also, though it does not come under the purview of this subcommittee, there is one other clear and obvious alternative to long-term care of chronically mentally ill veterans, and that is compensation. VVA has again and again reported VA's bias against

compensation claims for PTSD, a bias which results in a much higher utilization of long-term care than necessary.

PTSD-disabled veterans whose disability compensation is lower than it ought to be are subjected to a variety of current day stresses that exacerbate their conditions: anger, injustice, anguish over their unrecognized symptoms, and most important, stresses around finding and keeping work that will support them.

The VA's refusal to rate disabilities for PTSD at comparable levels to physical injuries stems from a bias for visible disabilities that is a vestige of the military's age-old presumption of malingering. It has no place in modern medicine.

For every two soldiers in Vietnam who suffered physical wounds, three were subject to clinical-level PTSD. Minimizing these bias and fairly compensating these veterans is the best guarantee against having to provide long-term care to veterans who could be rehabilitated instead. The VA's pinch-penny ratings for PTSD save nickels and waste lives. I wonder if there is any veteran's advocate here today who does not know of at least one veteran who decided that suicide was the only alternative to life-long struggles with the VA over claims for compensation or life-long institutionalization.

We owe both physical and mental injuries the same respect, the same competent care, and the same fairness in adjudications.

Mr. Chairman, this concludes our testimony.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Crandell appears on p. 95.]

Mr. ROWLAND. Mr. Grandison.

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Mr. Chairman, and members of the subcommittee, good afternoon. Mr. Chairman, the VA has made commendable first steps toward increasing non-institutional methods of care for the chronically mentally ill. For example, the homeless chronically mentally ill program was begun in 1987 and since that time the VA has had contact with approximately 10,000 veterans per year.

VA estimates that from one-third to one-half of the Nation's homeless are veterans and the number of homeless veterans could be as high as 250,000. Moreover, two-thirds of that number are likely to be drug or alcohol addicted.

VA also states that up to 45 percent of those enrolled in this program have serious medical conditions. Veterans who need psychiatric and medical care are aided through VA clinics and community-provided rehabilitative services.

Even more spectacular is the success of the post-traumatic stress disorder program for which the Congress has also been heavily committed through specified incremental appropriations. The National Vietnam Veterans Readjustment Study claims that approximately 500,000 Vietnam-era veterans need treatment for this disorder.

The noninstitutional options such as these could be repeated for other types of mental illness. Unfortunately, because of the perversity of current entitlement rules the majority of the core group veterans cannot be offered outpatient care. As a result, they are either provided more expensive hospitalization or, more often, denied access to VA care altogether.

This is but one glaring example of the need for entitlement reform. While the VA has made a start in shifting to noninstitutional modes of care, it is far short of what is required if it is to earn a place in tomorrow's competitive medical market. To meet acceptable standards of efficient and economic delivery of care, much more emphasis, including capital investment, needs to be placed on ambulatory programs for the chronically mentally ill veteran.

Therefore, PVA recommends the following:

1. Enact veterans entitlement reform to mandate full continuity of care, with special emphasis on expanded outpatient care for all core group veterans.

2. Provide incremental appropriations for expansion of VA plant facilities designed for ambulatory medical programs.

3. Provide the staffing and resource enhancements for 30 existing long-term psychiatric care facilities.

4. Provide 150 additional homes for therapeutic residencies for veterans' industries programs and provide these programs as joint ventures with non-profit entities.

5. VA should expand its nationally recognized expertise in geriatric medicine by supporting residencies and fellowships in geriatric psychiatry in no fewer than 10 VA medical centers.

Mr. Chairman, that concludes my testimony. I welcome any questions you may have.

Mr. ROWLAND. Thank you.

[The prepared statement of Mr. Grandison appears on p. 111.]

Mr. ROWLAND. Mr. Magill.

STATEMENT OF JAMES MAGILL

Mr. MAGILL. Thank you for the opportunity to present the views of the Veterans of Foreign Wars.

Given that a significant number of this Nation's veterans are suffering from PTSD as well as other mental disabilities related to their service in the United States armed forces, the VFW commends the chairman and members of this subcommittee for holding this hearing. Although the wounds of these brave men and women may not be physically apparent, the pain is nonetheless real and they certainly deserve all the help a grateful Nation can provide.

The Department of Veteran's Affairs psychiatric programs indeed serve a unique part of the veterans. VA psychiatric programs serve patients who would have little or no access to mental health outside the VA system. Although veterans are vulnerable to all the psychiatric disorders found in nonveterans, they are at particular high risk with respect to homelessness, substance abuse, severe psychosis, and post-traumatic stress. These conditions often feed on each other and providers must coordinate responses to best treat the underlying roots of the veteran's psychosocial disorder.

Without the programs provided by VA, chronically mentally ill veterans often lack food, shelter, or adequate clothing. Alcohol or drug use is often a substitute for rehabilitation to alleviate the veteran's pain and confusion. Mr. Chairman, programs administered by VA often successfully rehabilitate mentally ill veterans and allow them to regain their independence. One of the most important aspects of these programs is that encourage development of

independent living skills for the less impaired veteran who might otherwise be warehoused.

Unfortunately, due to budgetary constraints there are waiting lists for enrollments in these important programs. We believe VA should establish short-term care with more intensive therapy to augment its help to the chronically mentally ill.

As previously stated by Mr. Grandison, from one-third to one-half of our Nation's veterans are homeless, and they are mostly Vietnam-era veterans. One area of concern is the fact that VA may be releasing mentally ill patients from long-term care facilities too soon or not providing the patient with adequate support. The veteran either ceases to take his medication or in some cases sells or trades his medication in order to purchase alcohol or non-prescribed drugs. The end result is a rapid deterioration of the progress obtained as a patient in the long-term psychiatric care area.

VA should expand homeless veterans programs that focus on enhancing a veteran's independent living skills.

In closing, VFW believes the VA has made great strides in its treatment programs of the chronically mentally ill. Its research role in the treatment is highly respected and considered essential by experts in the field. In fact, the VA's research capability is so well regarded that the National Institutes of Health contribute financially and materially to its efforts.

Considering the resources VA has been provided they are doing a good job. However, it has to be noted that considering the workload facing VA they are still severely underfunded and understaffed. While nursing staff levels have slightly improved, there is still a shortfall in the intensive care and the critical skill care level.

While funding is, of course, critical to the success of any program, the care of the chronically mentally ill rely solely on dedicated professionals to treating the needs of a highly deserving and extremely vulnerable component of the veteran population. Recruitment and retention of these highly specialized health care people must be established as a priority within the Department of Veterans Affairs.

This concludes my statement.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Magill appears on p. 117.]

Mr. ROWLAND. Mr. Prigmore.

STATEMENT OF CHARLES PRIGMORE, PH.D.

Mr. PRIGMORE. Mr. Chairman, and members of the subcommittee, I am going to start off with an introduction and then take two or three paragraphs from my written testimony.

Unlike some of the other groups, we feel a need to indicate why the American Ex-Prisoners of War is interested in this particular subject. All of us spent anywhere from 1 to 5 years in the hands of an enemy, locked up, with the decisions being made for us, having a feeling of helplessness, leading to considerable anxiety and depression. We didn't know what was going to happen from day to day, whether we were going to be shot or killed. Therefore, we un-

derstand the pressures and anxieties of hospitalized chronically mentally ill veterans.

As a result of that experience, when I came back to the United States I spent about 20 years in the correctional field—prisons, parole, probation—and subsequently became a professor of social work. Since I retired I have been a volunteer with the VA doing educational therapy. I want to give you a couple of examples of men that I have worked with because it bears on this problem.

One of them about a year ago told me, "Prigmore" he said, "don't let them put you in a nursing home." He said, "This is just a slow death and you aren't going to like it." About 3 months later that man was dead.

I have got another one that is 97 years old, just had his 97th birthday, and he told me "There's nothing to do here." Actually, there are a lot of activities in the particular nursing home he is in. There are a great many things going on. What he really meant was "I am not with my family, grandchildren, great-grandchildren, I am not surrounded by my own possessions, I am not with friends," and so forth.

So it is hard to make a hospital or any kind of an institution into a place where a person feels a sense of self-worth and dignity.

Our primary recommendation, that of the American Ex-Prisoners of War, is that the VA receive enough funds to expand its use of community placement homes, group homes, and subsidized housing for the chronically mentally ill. We all realize that extended hospital care inevitably results in loss of individual self-worth, privacy, communication skills and orientation to reality. However, some hospital care will continue, since there are patients that are going to need hospital care from time to time, either intermittently or in some cases extended periods of time. We recommend better training for VA personnel.

On the other hand, release of chronically mentally ill veterans to the community without preparation, planning, assurance of suitable housing, and continued supervision results in a strong likelihood of acting out behavior, inability to cope, and even suicide. Communities need to be assured that the VA will maintain professional supervision when a veteran is placed in a community placement home or residential care home, and that the sponsors or caretakers are thoughtfully selected and help to handle problems that will arise. Some training of sponsors does take place now, but we think it needs to be expanded and strengthened.

In short, we need to expand the VA alternatives to long-term care such as employing more staff to develop and supervise community resources and expanding the system of community placement homes, group homes, and subsidized housing.

This ends my testimony, Mr. Chairman.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Prigmore appears on p. 121.]

Mr. ROWLAND. I have just a couple of questions I want to ask. There will be some others that we will want to submit for the record.

Let me ask, do you share the view expressed by your colleague from the American Legion that the VA must develop a revitalized

attitude towards the care of the chronically mentally ill patient? Anybody there.

Mr. CRANDELL. Yes. I think what we are seeing from a wide variety of witnesses and we have certainly experienced is that sense that "the physical illness we can see is the real illness, and the mental illness, we are not so sure."

Mr. PRIGMORE. Well, I thoroughly agree. I have seen instances in which a person would go into the VA for some kind of intermittent or chronic mental illness, and the staff not recognize what the illness was and what it would do to his behavior and sometimes staff treats him as if he were a bum or somebody that was malingering or refusing to do anything. I definitely think staff need to be better qualified, better taught, and given a thorough understanding of what, for example, medicine does to a person. If he is overmedicated a person can change his personality almost totally, and a lot of the VA staff don't fully recognize this.

Mr. MAGILL. What I said in my statement, you know, was that we thought that VA considering the funds that they have they are doing a good job, and I will stand by that now. I think that if VA would channel the funding to the program I think this would also allow not only for VA employees to better serve the patient but at the same time would allow VA to give them more training in what they need.

So I am not saying that the funding is the problem, but I think that it definitely would eliminate some of the problems that are now being faced.

Mr. GRANDISON. Mr. Chairman, the VA has made significant gains in treating chronically mentally ill veterans. As stated in earlier testimony, the VA treats a significant number of veterans who could not necessarily get similar or comparable treatment in the private sector. However, we do recognize that a shift must be made from inpatient treatment to noninstitutional alternatives of care. But this also must be coupled with increased funding and a commitment to utilize the resources in a narrow way. In essence, focus on the things such as, mental illness care for veterans which the VA has distinguished itself in.

Mr. GREER. May I add a word, Mr. Chairman, on the business of prioritizing serious mental illness versus less serious mental illnesses or disorders or mental health kinds of concerns. Unless my colleague organizations at this table and committees like yours watch the caregivers and providers, it is our experience that so quietly, the County Commissioners, in deciding the local mental health budget, the first thing you know mental health kinds of programs versus mental illness program, wind up and get funded.

You have got to keep a vigilant eye, and that is why advocacy for serious mental illness, I think, is critical. You have got to keep a vigilant eye focused on the most serious needy people, in this case the seriously mentally ill with life-long illnesses.

Mr. ROWLAND. You all know there has been a virtual straight-lining of the VA budget over the past several years. I guess that nevertheless all of you would agree that there needs to be some reallocation of funding priorities to improve the care and the rehabilitation potential of those people who are chronically ill. All of you all feel that to be the case?

Mr. GREER. Oh, yes.
Mr. GRANDISON. Yes, sir.
Mr. VITIKACS. Yes, sir.
Mr. MAGILL. Yes, sir.
Mr. PRIGMORE. Yes, sir, I do. Very much.

Mr. ROWLAND. I can recall when I was a youngster back in the 1930s the first person that I saw who—they called it shell shock then. I remember there was a fellow that—I was a little fellow sitting on the front porch, and there was a fellow that would walk up and down the street. I know now, or rather I learned later, after I became a doctor, this guy was schizophrenic and he was obsessive compulsive. He would walk from his home to town, which was probably no more than a quarter of a mile, and it would take him more than an hour to do that, because he would walk a little ways and then he would stop and go back, and it was back and forth. I realize he was really chronically mentally ill.

I think that this hearing has really touched a nerve and has focused on what we really need to focus on. I have known this for years as a family practitioner. That chronically mentally ill people in the private sector didn't get the kind of consideration that they should get.

I really am grateful for all of you coming today and giving your testimony, and we will certainly pursue this. I am very grateful for the information that you have given us.

We stand adjourned.

[Whereupon, at 1:42 p.m., the subcommittee was adjourned, to reconvene subject to the call of the chair.]

APPENDIX

TESTIMONY OF CONGRESSWOMAN MARCY KAPTUR
before the Subcommittee on Hospitals and Health Care
of the House Veterans' Affairs Committee
June 29, 1993

Mr. Chairman, I thank you for your leadership in holding these hearings and for this opportunity to testify today. May I offer my wholehearted support and cooperation as a Member of the Veterans Affairs, Housing and Urban Development, and Independent Agencies Appropriations Subcommittee as you assess VA care of chronically mentally ill veterans. In my opinion, there is no more overlooked set of illnesses than those involving the chemistry and function of the brain. The need to address this issue is evidenced by the finding that 40% of veterans treated at VA medical facilities have been diagnosed with psychiatric disorders. Each year approximately one-third of the hospital beds in VA facilities are occupied by patients with these illnesses.

First, let me address the issue of research so fundamental to achieving breakthroughs to properly treat these illnesses. Although 40% of VA patients receive treatment for mental illness, only 11.2% of the FY92 VA medical research budget, the latest year for which figures are available, was directed toward research in this area. Further, research psychiatrists and neurologists are exceptions on the peer review committees the VA employs to select and award research grants. Thus, it is not surprising these illnesses do not receive the attention they warrant. <u>There is a serious need to realign VA research priorities to parallel the characteristics of patients treated.</u>

Despite receiving only 11.2% of the VA medical research budget, the results of serious mental illness research have enabled veterans to become functional again. Once they would have spent the rest of their lives in hospitals, disabled by hallucinations, crippling paranoia, unremitting depression, or a gut-wrenching panic disorders. Even greater breakthroughs should be expected during this "Decade of the Brain" because of growing national awareness about the necessity of significant research advances in these

fields. A recent NIMH study prepared for the Senate Appropriations Committee indicates that clozapine, for example, has helped nearly one-third of the people diagnosed with schizophrenia who had previously been unresponsive to all other treatments. Due to serious side effects, however, research is continuing to develop medication with clozapine's benefits without some of its side effects. There is no better time to increase support and attention to VA mental illness research and treatment - especially such serious debilitating illnesses as schizophrenia and bipolar disorder.

A coordinated emphasis on psychiatric research by the VA and the National Institutes of Mental Health (NIMH) would help a great deal, and would be most beneficial, to achieving even greater success in the treatment of chronically, mentally ill patients. Language included in the House VA, HUD, Independent Agencies appropriations report for FY94 recommends that the VA and NIMH Research Review Committees jointly work together to submit a report on ways to improve coordination of psychiatric research efforts. I believe testimony you will hear today from NAMI will elaborate on their plans for coordination with the VA.

Research directly leads to treatments for mental illness that lead not only to a more humane existence for millions of citizens but incredible cost savings as well. The NIMH study indicates that treatment success rates for panic and bipolar disorders are 80%, major depression 65%, and schizophrenia 60%, while angioplasty and atherectomy, two cardiovascular treatments, compare at just 41% and 52% respectively. The treatments, both drug and psycho-social, promise incredible savings to the U.S. economy, which lost over $136 billion in 1991 due to direct and indirect expenses associated with mental disorders. NIMH calculates that the development of lithium alone already has saved more than $40 billion since 1970. These calculations are based on the U.S. population at large, of which 22% will experience some kind of mental problem during their lifetimes.

When one considers at least 40% of our veterans are similarly affected, the impact on the veteran population and the VA should be even greater.

The need for coordinated research efforts is essential. You may remember past attempts to establish clinical centers to focus more research on all mental illnesses, modeled after existing VA Geriatric Research, Education and Clinical Centers (GRECC's). Although these attempts were unsuccessful, this is the type of approach needed to encourage additional research which will constructively benefit veterans who now often are turned back out into society, only to return for the same treatment. The three centers currently supported by the VA, which conduct laboratory and clinical research in schizophrenia, point in the direction we must go.

Increased support of the VA's Health Care for Homeless Veterans (HCHV) Program (formerly the Homeless Chronically Mentally Ill (HCMI) Program) offers another effective means to treat chronically, mentally ill veterans. At least one-third of our nation's homeless are veterans. A large percentage of these homeless veterans also suffer from mental illnesses, often complicated by alcohol or drug addiction. In my Northwest Ohio district, a VA study conducted last year found that of the approximately 4,500 homeless individuals in Northwest Ohio, 1,500 - 1,700 were veterans. The study also found that of that number, approximately 65% were alcohol dependent and 35% were drug dependent, many presenting with dual diagnoses. These distressing figures led me to pursue the establishment of an HCHV Veterans program in Toledo, Ohio, which, I am glad to say, will be fully operational within four months. By working with various community organizations and walking the streets in areas common to the homeless population, HCHV outreach workers will make contact with homeless veterans. It is estimated that the Toledo HCHV program will identify, assess and rehabilitate 600 homeless chronically, mentally ill veterans each year. Nationally, since its inception in 1987, the HCHV program has helped over 30,000 homeless veterans suffering from psychiatric and substance abuse disorders in

26 states and the District of Columbia. And over 8,000 were placed in non-VA residential treatment facilities.

I would like to tell you a story about one homeless veteran. The day before Thanksgiving of 1992, a story appeared in the local newspaper describing Phil, a man who lived in a tent on the banks near the Maumee River. An old school friend of Phil's read the story, and went to the bridge to pick up Phil and take him home for Thanksgiving. His friend went on to assist Phil in trying to find medical help and job training and literally had to beg doctors to examine Phil, and others to find him shelter. Then he and Phil came to meet with me in my office shortly after Thanksgiving. During the course of our conversation, his friend told me that Phil had been diagnosed recently as suffering from paranoid schizophrenia. I asked his friend if Phil was a veteran. They both looked and looked at each other and Phil perked up and answered yes, he was a veteran. In all of the agency contacts Phil and his friend had made in the previous weeks, no one had asked whether Phil was a veteran!

Phil had been on the street for years with no care, because no one had ever found him and, once they had, inquired as to whether he was a veteran, and thus eligible for VA assistance. After my question, with his friend's help, Phil was admitted into the VA mental health care system, was given medicine to help his condition, applied for and began receiving benefits, and consequently was set up in an apartment. Thanks to the VA health care system, one less veteran is forgotten on the street.

There is a vast unmet <u>need for residential treatment or transitional housing</u> for mentally ill veterans treated at VA medical facilities. I will never forget a scene I witnessed while visiting the Hines VA Medical Center near Chicago. A veteran was being admitted to the Hines Hospital for the 17th time. Each time, after being treated and becoming acclimated to his medication, he was sent back to the streets of Chicago. But sure enough, nine months later he wandered out or was brought back to West Chicago for more

treatment. Would not transitional housing, in which a veteran such as this could be monitored, be more effective in the VA's long-term rehabilitation efforts?

The VA, HUD, and Independent Agencies FY94 Appropriations bill, which was approved by the House yesterday, directs $10 million to implement the homeless veterans comprehensive service program authorized by this Committee last year. As you know, this program offers federal support to community based organizations who provide transitional housing assistance, outreach, rehabilitation services, and vocational counseling and training assistance to homeless veterans. I commend you on recognizing the need for a program such as this, which directly reaches out to the hundreds of thousands of veterans who walk our streets each day and offers them concrete, tangible help, and urge you to continue pursuing the problem in this vein.

Encouragement and support of expanded VA mental illness research, rehabilitation of homeless chronically mentally ill veterans, and transitional housing which allows for monitoring of veterans treated for mental illness, are constructive ways in which to return these veterans to the lives they wish to live. I urge you to consider these methods as you decide how the VA can assume a more significant national role in focusing care and treatment of chronically mentally ill veterans. Thank you again for this opportunity to testify.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

on

"VA Care of the Chronic Mentally Ill"

presented to

THE HOUSE COMMITTEE ON VETERANS AFFAIRS

BY

JOHN A. TALBOTT, M.D.

PROFESSOR & CHAIRMAN

DEPARTMENT OF PSYCHIATRY

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Tuesday, June 29, 1993

Mr. Chairman & Members of the Committee:

Introduction

I am John A. Talbott, M.D., Professor and Chair of the Department of Psychiatry, University of Maryland School of Medicine. I am also a Viet Nam veteran and a past president of the American Psychiatric Association, representing 38,000 psychiatrists. I have written or edited over 120 books and papers, most of them on the subject of the long-term mentally ill. I was also the first chair of the American Psychiatric Association's Committee on the Chronic Mentally Ill and chaired the Special Study on the Chronic Mentally for President Carter's Commission on Mental Health.

The subject I have been asked to address today is a critical one; for your committee, for the VA and for the long-term mentally ill; that is, the optimal clinical care, research needs and training of professionals to care for those persons suffering from episodic or continual diseases of the brain such as schizophrenia, that render them unable to work, maintain normal family lives and even conduct the affairs of everyday living we take for granted, such as personal care, buying and preparing nutritious meals and social interaction.

The Department of Veterans' Affairs is in a pivotal position to influence the future direction of care, research and training regarding this population, estimated to number at a maximum - 3.4 million persons suffering from these illnesses and at a minimum - 1.7 million who are both ill and disabled for long periods (1). The VA can influence the future direction of care, research and training because it: (1) serves a population that is older than the American population, and (2) cares for a higher percentage of persons suffering from chronic mental and medical diseases than other care systems. In addition, its activities can influence national health care reform because it: (4) has a national health care system, (5) operates as a single payer system, and (6) has an array of services for the long-term mentally ill including Viet Nam

veteran drop-in centers, specialized programs for the homeless mentally ill and domiciliary care facilities (2,3).

The chronic mentally ill

Let me start out by defining and describing the population. A noted sociologist (4) wrote that the chronic mentally ill are those persons who might be in long-term care facilities today, but for the deinstitutionalization movement that has reduced public psychiatric hospital populations by 84% since 1955 (from 560,000 to 94,000). Those suffering from chronic mental illness range in age from children to the aged; but since their illnesses usually start in late adolescence and they do not die from the disease, they live long and disabled lives. Very few are able to work; 75% have no or minimal family lives; and 2/3rds continue to have symptoms such as hallucinations and delusions, long after they are discharged from hospitals (1).

If you think of the chronic mentally ill as those elderly people who sat placidly in asylums 50 years ago, you are mistaken. For today, especially those who are Viet Nam veterans, they live for the most part "in the community" and often on the streets; they are plagued by the same accessibility of drugs and alcohol as all Americans; and they suffer not only from mental illnesses such as schizophrenia and manic-depression, but also post traumatic stress disorder (PTSD) and numerous chronic medical conditions.

The current situation

What is the VA doing and not doing to provide clinical care for the chronic mentally ill? The Veterans Administration is doing a lot but not enough in treating and rehabilitating this population. On the one hand, as mentioned before, some services have been instituted, including:

- outreach and drop-in centers
- traditional inpatient and outpatient care
- newer alternatives to traditional care and nursing home care such as day hospitals
- domiciliary care facilities for those in need of long-term custodial care.

However, in my estimation, I do not think the VA is doing a good job taking care of the chronic mentally ill; I do not think it has focused its attention on this population as it has on other afflicted veterans' groups; nor has it been in the leadership in caring for this population. Needless to say, I think it should be in the forefront in all three areas.

Why do I say this? First because, with the exception of domiciliary care, the VA has not "pioneered" in the development of

- model programs that serve as alternatives to hospital care
- model housing initiatives
- model systems that track patients and serve as the glue to reduce fragmentation of programs.

Likewise, with the exception of innovators like Robert Liberman, M.D. at the Brentwood VAMC, the VA has not focused on developing a system-wide focus on the population by developing:

- a continuum of alternatives to hospital care, from halfway houses to supportive living to independent apartments,
- a targeting of the population for application of combined psychopharmacological and psychosocial intervention coupled with social and vocational rehabilitation, and
- a system of case or care management to help afflicted patients utilize the VA and other governmental benefits and community services they are entitled to.

At present, not enough veterans are reached by the services that do exist, especially the younger Viet Nam vets. More needs to be done to seek out, involve and treat chronically ill vets in the community and to establish and evaluate more alternatives, especially to nursing homes, such as new types of board and care homes, domiciliary care and home care. The Institute of Medicine, in its study of the long-term care needs of Americans, concluded that the needs of the chronic mentally ill were almost identical to those of other long-term populations, eg the frail elderly, and that any national health care strategy to address long-term care should include the chronic mentally ill (5).

Proposal

What can the VA do? First, it can invest in designing "models" that suit populations that are special to the VA, e.g.

those chronic mentally ill veterans who suffer from substance abuse, or PTSD or have suffered physical trauma.

Second, it can invest in providing outreach services, a continuum of care, adequate housing and case management for every chronically ill veteran.

Third, it can invest in a focus on education and training of all professionals who need to work as a team in treating and rehabilitating the chronic mentally ill veterans. While the medical schools affiliated with VA facilities, in some cases train persons to care for this population, the current effort is inadequate. To bring VA professionals abreast of modern practice, there must be a system-wide training program of mental health professionals in care, research and education of other professionals about these disabling diseases. A model for a national program linking state mental health systems with public and private medical school departments of psychiatry, funded by the Pew Foundation, has demonstrated that after only 3 years, the number of trained professionals, research projects and training activities has increased dramatically (7). This project, which has a national office in Washington, has utilized over 30 university and public system experts to make 2-3 day on-site on-going consultations as well as trained an interdisciplinary faculty of 15 who have conducted over 30 national, regional and local workshops.

And finally, it can invest in a sophisticated effort to measure differences in different VAMC's efforts - through mental health services research. VA-supported basic research on crippling mental illnesses has ground to a inexplicable halt. Health services research, which is designed to evaluate what services, delivered in what manner, produce what outcomes, at what cost - has never been well-supported in the VA. Restoration of the budget for VA basic research and initiation of a new initiative in health services research, such as that targeted to the chronically ill in city mental health systems, funded by the Robert Wood Johnson Foundation, must be undertaken (6). The RWJ Project has demonstrated what many of us suspected, that while services exist to care for the population, they are too few and too fragmented;

and that only by a concerted "systems approach" to pulling services together and providing housing and case management services can their lot be improved.

Summary

Just as the VA has had a pivotal influence on mental heath services throughout the country in areas such as PTSD, so now it should focus on the group that represents the core problem for all of us, those veterans suffering from chronic mental illness.

I will be delighted to answer questions now or from you or the staff as followup.

References

1). Minkoff, KA Map of the Chronic Mental Patient in Talbott JA (ed): The Chronic Mental Patient; Problems, Solutions and Recommendations for a Public Policy. Washington DC, American Psychiatric Association, 1978.

2). Rosenheck R et al: The Fourth Progress Report on the Homeless Chronically Mentally Ill Veterans Program. West Haven, CN, Dept of VA Medical Center, 1991.

3). Leda C et al: The Fourth Progress Report on the Domiciliary for Homeless Veterans Program. West Haven, CN, Dept of VA Medical Center, 1993.

4). Bachrach L: Deinstitutionalization: An Analytic Review and Sociological Perspective, U.S. Department of HEW, NIMH, Washington, DC., 1976.

5). Aiken LH et al. Toward a National Strategy for Long-Term Care of the Elderly. Washington DC: Institute of Medicine, National Academy of Sciences, April 1986.

6). Shore MF and Cohen MD: The Robert Wood Johnson Foundation Program on Chronic Mental Illness: An Overview. Hospital & Community Psychiatry 41:1212-1216, 1990.

7). Final Report of the State-University Collaboration Project. Washington DC, American Psychiatric Association, 1993.

TREATMENT AND REHABILITATION OF INDIVIDUALS WITH CHRONIC MENTAL ILLNESS

Jerome V. Vaccaro, M.D.
Chief, Community and Rehabilitative Psychiatry
West Los Angeles V.A.M.C.

Director, Community Psychiatry Programs
Assistant Professor of Psychiatry
UCLA School of Medicine

Testimony Before the U.S. House of Representatives
Committee on Veterans Affairs'
June 29, 1993

Thank you for inviting me today to provide testimony to your committee. I also wish to thank you for your concern and attention to individuals who suffer from mental illnesses. My name is Jerome V. Vaccaro. I am a psychiatrist with expertise in the fields of community psychiatry and psychiatric rehabilitation. I have spent my career in public service, beginning with various county and state mental health authorities and joining the Department of Veterans' Affairs at its West Los Angeles Medical Center in 1989. I train psychiatrists to work in public sector and community settings. I direct the West Los Angeles V.A.M.C. Community and Rehabilitative Psychiatry Section, which provides a comprehensive array of rehabilitative services to mentally ill veterans. I also coordinate community psychiatry training for the UCLA Department of Psychiatry and Biobehavioral Sciences. My clinical work involves the provision of psychiatric and rehabilitative services, the design of new treatment and rehabilitation approaches, and the testing of these new approaches to judge their effectiveness.

In my testimony today, I will describe some of my experiences and suggest principles to guide decision-making about the design and implementation of clinical programs. In brief, I will suggest that individuals with chronic and severe mental illnesses are treatable and can be rehabilitated. In order to accomplish this, our systems of care must be well-organized and coordinated, offer comprehensive services, and stress re-entry into the community rather than maintenance in costly hospitals. Cost efficiency

must be a paramount concern in the design of new interventions and delivery of health care services. I will first demonstrate these issues by telling you about a patient with whom I have worked over the past several years.

John is a 44 year old veteran who served in the military in Viet Nam. His tour of duty included exposure to combat, and he performed with distinction. Unknown to his friends and colleagues, he began experiencing the symptoms of schizophrenia during his late teens. At first, the symptoms were mild and not bothersome--sleep difficulties, social isolation, difficulty concentrating. Gradually, he developed some of the "core" symptoms of the illness, including hearing voices (hallucinations) and believing things which were clearly out of line with reality (delusions).

Throughout his tour of duty, he kept these symptoms to himself, fearing that he would be placed in a hospital for a long period of time. This fear was fueled by John's experience of his grandfather's own struggle with schizophrenia, in which he (also a veteran) was hospitalized for most of his adult life. His grandfather died while living on a long-term care psychiatric ward of a veterans hospital.

When John returned home, he went to live with his family in a large east coast city. He spent some time in college and eventually secured employment with the telephone company. He married and had two children, remaining psychotic throughout this period of about eight years. In spite of this, John maintained his job and outwardly functioned rather well. In the late 1970s, John's symptoms became so disabling that they began to affect his family relations and ultimately his work. This was complicated by his increasing use of alcohol in an attempt to reduce the anxiety and fears generated by the hallucinations and delusions. As a result of his impairments, he was laid off from his job in 1980.

Following this, John's condition rapidly deteriorated. His sense of identity and self-worth, dependent to a large degree on his identity as the bread-winner for his family, evaporated. As his symptoms became progressively worse, his family and friends expressed their concerns to him. Rather than seeing this as helpful, John experienced their interest as threatening. He became more and more isolated, until finally he left home and began wandering the streets. After several months on the streets, John was arrested for vagrancy. After spending several nights in jail, he was transferred to the local Veterans Administration Medical Center. Thus began his career as a consumer of mental health services.

Over the next four to five years, John was repeatedly hospitalized for the symptoms of his mental illness. He was placed on a succession of medications, never receiving or understanding an explanation of his condition or its treatment. Each time he was discharged from the hospital, he was given an appointment with a different doctor at a local V.A. outpatient clinic, often having to wait several months for this appointment. He acknowledges that he was greatly dissatisfied with his care, citing doctors' and other clinicians' lack of attention to his vocational aspirations, his being overmedicated to the point of being seriously impaired by side effects, and the lack of coordination among his many providers. He was very unhappy that during these years, he spent more time in the hospital than in the community. In fact, he was hospitalized over thirty times at a cost which ran into the tens of thousands of dollars each year.

In 1989, John moved to Los Angeles and sought care at the local V.A. Medical Center after he again became severely symptomatic. He encountered a care system much like that in his home city. He was rehospitalized repeatedly, placed on a dizzying array of medications, and given appointments to myriad clinics and programs. In early 1990, John entered one of the psychiatric rehabilitation programs offered at the West Los Angeles V.A. Medical Center. While the outpatient clinic and the rehabilitation program did not initially coordinate their efforts, leading to sometimes conflicting advice, John found the emphasis placed on the importance of returning to work very rewarding. Where he once was poorly compliant with his treatment, John now fully complied with recommendations.

In 1990, John asked to have all of his care provided by one coordinated group of doctors and clinicians. On an experimental basis, this was established, compelling clinical services which had previously been widely separated to coordinate their efforts. This involved clinicians talking to one another on a regular basis in order to coordinate John's care. As a result, John's medication regimen was simplified so that it minimally interfered with his work performance. He eventually joined a supported employment program and now works in the community and sees me once or twice each month for brief visits. He has not had a single rehospitalization since his entry into the coordinated program, and reports satisfaction with his life and his treatment.

Who are the Chronically Mentally Ill?

One in three Americans will suffer a disabling mental illness at some time during their lifetime. For most, this illness will be limited in duration and require a moderate amount of treatment and rehabilitation services. For the 1-2 % of Americans who suffer from severe and disabling mental illnesses such as schizophrenia, schizoaffective disorder, bipolar affective disorder (manic-depression), and post-traumatic stress disorder, their illnesses are life-long and require ongoing treatment and rehabilitation. We now know that illnesses such as schizophrenia are biologically based and their courses are modified by the type and degree of stress experienced by the individual.

It was believed, until recently, that persons with schizophrenia were doomed to a life in which their illnesses would invariably progress to the point where they would be non-functional. We now know that this is not true. In fact, we now know that with the proper combination of treatment and rehabilitation, most individuals with these illnesses can lead productive, symptom-free lives. All that is needed is an understanding of what supports and services are needed by these individuals to maximize their functioning.

What is Psychiatric Rehabilitation?

Much like its counterpart in general medical care, physical rehabilitation (physiatry), psychiatric rehabilitation is a field whose main goals are to help patients compensate for their impairments, reduce disability and handicap, and maintain a productive lifestyle. Patients may receive training in essential social and independent living skills, receive vocational training, be given work opportunities, or we may try to modify the environments in which they live, providing "social prostheses." Psychiatric rehabilitation differs from other forms of psychiatric care in its strong emphasis on interventions which are designed to maximize functioning. The acquisition of psychological insight is seen as a secondary phenomenon.

What are some of the elements of Psychiatric Rehabilitation?

The clinical practice of psychiatric rehabilitation joins together three sets of factors:

1. Providing medications which are specifically keyed to the type and severity of psychiatric symptoms at doses which do not produce disabling side effects such as sedation and neurological impairments which would interfere with rehabilitation.

2. Teaching social and coping skills needed to overcome life stresses.

3. Providing a range of supportive social services, including housing, transitional and supported employment, financial support, and case management, designed to sustain the individual in the community.

How important is vocational rehabilitation, and is it successful with this population?

Most individuals with chronic mental illnesses are unemployed or seriously underemployed. When supportive services are provided, the great majority of these individuals can become involved in productive endeavors ranging from full-time competitive employment through part-time employment, transitional or supported employment, volunteer work, and schooling. Furthermore, virtually all chronically mentally ill individuals identify occupational concerns as being extremely important to them. In order for efforts to be successful, a comprehensive array of services including the following should be available to mentally ill veterans: assessment, work hardening, work skills training, job finding skills training, and job coaching. The Department of Veterans' Affairs Compensated Work Therapy/ Veterans Industries Program provides an ideal environment for these programs and can be used in such a way that it is extremely cost effective. For example, at our center we have a number of

small businesses which provide services to the community such as selling plants and fresh produce, repairing office machines, and refinishing antiques. In each of these operations, patients are paid for their labor and receive training to help them reintegrate into the community.

What are some important issues in the design of treatment and rehabilitation services?

First, most health care systems are not well designed to support community adaptation of individuals with chronic illnesses. We rely either on acute, short-term "fixes" such as acute hospitalizations when symptoms get out of control, or on long-term hospitalization and containment. In fact, most public health care systems spend the great majority (as high as 70%) of their budgets on more expensive inpatient care while most of their patients reside in the community and rely on outpatient services. Systems in which the "money follows the patient" have been dramatically effective in providing cost-effective, humane care which actually reduces patients' reliance on social and health care services. *Resources should be redirected toward community-based care.*

Second, most health care systems are extremely fragmented, providing discontinuous, uncoordinated care. The result of this is that patients receive sub-optimal care and excessively use more costly services such as inpatient and emergency care. We

should *reorganize clinicians into Continuous Treatment Teams*, composed of clinicians from different disciplines who maintain ongoing responsibility for patients as they move among the different components of service systems including inpatient, outpatient, day treatment and other services. Case management has emerged as an effective and widely accepted intervention to ensure this continuity of care.

Third, *all clinical services should be continuously evaluated and monitored for their effectiveness*. Outcome analysis has been ignored or relegated to the back burner. We should critically evaluate our services to see that they reduce relapse and rehospitalization, improve functioning, improve vocational outcomes, and improve quality of life in cost-effective ways.

What are some of the recent clinical research findings in the field?

In one year, an average of 80% of chronically mentally ill individuals who are untreated will relapse and require rehospitalization. With effective use of medication alone, this relapse rate is reduced to 40%. When psychiatric rehabilitation interventions such as social skills training are added, this relapse rate is reduced to about 20%. Some studies have reported relapse rates less than 10% when medication, social skills training and case management have been combined.

STATEMENT OF BONNIE J. RILEY, MSW,
COORDINATOR, CONTINUOUS SUPPORTED SELF-CARE PROGRAM
COLMERY-O'NEIL VA MEDICAL CENTER, TOPEKA, KANSAS
JUNE 29, 1993

My name is Bonnie Riley. I'm a social worker at the Colmery-O'Neil VA Medical Center in Topeka, Kansas. I am the Coordinator for a psychiatric case management program called the Continuous Supported Self-Care Program. CSS-CP is a community based rehabilitation program for veterans who experience severe and persistent mental illness. Clinical case managers assist the veteran patients in their transition from the psychiatric inpatient ward and in their ongoing integration into the community.

In my 13 year career with the VA, I have worked in inpatient psychiatry, day treatment center, residential care, psychiatric nursing home consultation, and group living. The community based case management approach to rehabilitation of the chronic mentally ill is profoundly successful. Of the 107 veterans currently in CSS-CP, twenty-five have been outpatients for a year or more. These twenty-five veterans accounted for 6037 days of hospitalization in the year immediately prior to entering the program. Their first year in the program, these twenty-five veterans accounted for only 946 days of hospitalization. This is an 85% reduction in the occurance of inpatient care.

Quality of life for our veterans is an even more important aspect of community based psychiatric rehabilitation. Michael Sheer, a client and a member of the CSS-CP Consumer Counselor groups will speak to this issue from his personal experience.

(CUT TO VIDEO)

STATEMENT OF MICHAEL SCHEER
VETERAN CLIENT, CONTINUOUS SUPPORTED SELF-CARE PROGRAM
COLMERY-O'NEIL VA MEDICAL CENTER, TOPEKA, KANSAS
JUNE 29, 1993

(Mr. Scheer's statement was presented on video tape which he made June 18, 1993. This is a complete transcription of that statement.)

My name is Michael Scheer, I am a schizophrenic. I have been in the Continuously Supported Self-Care Program for about two years. I have been doing fine, I have been stable on my medications and made the adjustments to the community.

One of the things I have noticed is that being hospitalized is kind of depressing for most people, and a lot of times their self-esteem is at a pretty low level. I have been in the Continuously Supported Self-Care Program now for about two years, and I can tell you from my own personal experience and witnessing other triumphs of the program, that the mentally ill can be successful and complete the transition to the community with the proper funding and proper support group. They can conquer their fears and self-doubts and as they gain experience in the community they become more rounded persons. Their mental health actually improves.

I think this program is a great success. I think the case manager approach is a very good one. We get a couple home visits a month and a couple office visits a month, and they keep us posted on all the things that are going on, and the program has added stability and security to my life. I know that there are caring and concerned people ready to help me down the pathway of life should I have any problems whether they be mental, physical, or emotional.

In August of 1982, I had my regular Tuesday group meeting, and my social worker supervisor, Mrs. Riley, noted that I was a little psychotic. I later asked her what that meant. I didn't know what it meant and she told me I wasn't making any sense. Anyway, she decided to make a special visit at my home to check on me, to see how I was doing because she was concerned. And when she arrived, she found my breathing was messed up and my complexion was bad. She listened to my tale of woe and decided I was having some type of physical emergency. She took me to the hospital and I went to the Emergency Room where I went into congestive heart failure and suffered a full-blown heart attack. I think without the attention of a caring and talented physician, I probably would have died.

I have been in the Consumer Counselors for about a year. Mrs. Riley recruited me, and it has added some purpose to my life, giving me a job, something to be concerned about, and to do with my life. I take it seriously. It's a pleasant opportunity to talk to other veterans and voice our concerns, to learn about upcoming events, and to have some input to the management of the hospital - to represent the veterans and their feelings. Being in the same boat as they are, we can convey this to the staff. I think it is a very useful program, and I am happy to be in it.

As a Consumer Counselor, one of my biggest joys and satisfactions has been talking to discharge groups and sharing with them some of the tricks and experiences I've had that might be helpful for them in making the adjustment to community life. I try to think of something to tell them that might be a little uplifting to them and I had these thoughts:

> In this day of the all volunteer armed services, a lot of people have never had their life interrupted by their country's call and have never had to sacrifice monetary gain, career, or family to serve their country. Some veterans have suffered the horrors of war and have been disabled. Other veterans have accually given their very lives for their country. All have sacrificed. All have served. All are worthy of individual consideration of their needs.

Thank you for hearing my small voice. God bless America. God bless all of you.

REPORT OF OUTCOME FOR PATIENTS IN CSS-CP FOR 1 YEAR

Patient	No. of days of hospitalization during year prior to CSS-CP	No. of days of hospitalization during first year as out-patient in CSS-CP
1	310	11
2	151	0
3	164	0
4	162	1
5	120	35
6	183	14
7	145	83
8	341	0
9	123	32
10	167	26
11	365	0
12	181	2
13	365	0
14	150	46
15	193	66
16	277	33
17	322	252
18	365	0
19	262	0
20	365	114
21	365	0
22	174	92
23	226	33
24	196	6
25	365	100
TOTALS	**6037**	**946**
AVG. # OF DAYS	**241.48**	**37.84**
HOSPITALIZATION		
% OF CHANGE IN PATTERNS OF INPATIENT CARE		**84.3**
BY PATIENTS DURING FIRST YEAR IN CSS-CP		

Geriatric Psychiatry
in the
Department of Veterans Affairs Health Care System

Testimony before the Subcommittee on Hospitals and Health Care
of the
House Veterans Affairs Committee
June 29, 1993

Ira R. Katz, MD, PhD
Department of Psychiatry
Philadelphia VAMC
Professor of Psychiatry
University of Pennsylvania

I am Ira Katz, a geriatric psychiatrist at the Philadelphia Department of Veterans Affairs Medical Center and a professor in the Department of Psychiatry at the University of Pennsylvania. I am here to speak about the importance of geriatric psychiatry in the care of chronically ill patients within the Department of Veterans Affairs Health Care System. I speak from over 15 years experience in clinical care and research on the psychiatric disorders of late life. Because I am relatively new to the VA, I speak with the perspective of someone who is viewing this system in comparison with care as delivered in other settings.

This is a critical time to be reevaluating the care of patients with chronic mental illness for several reasons. One is related to the ongoing national process of health care reform. The extent of universal coverage for both mental illness and long term care have not yet been established. Nevertheless, health care reform presents both an opportunity and an obligation to reevaluate the care that is to be made available to elderly veterans. Another reason is related to the demographic imperative. The average age of World War Two veterans is now in the early 70's. They are currently among the "young-old", a group that is aging, but where chronic disease of a degree that affects day to day functioning is still the exception rather than the rule. By the year 2000, the population of veterans over age 65 will number over 9 million and they will constitute approximately two thirds of America's men in this age group. At that time, World War Two veterans will be among the "old-old", in the age where the majority have chronic disease affecting functioning and where the incidence of new cases of Alzheimer's disease will be at its highest.

Clarifications and Definitions

To clarify the discussion of the issue of aging and chronic mental illness, I would like to briefly define a number of relevant concepts.

"Comorbidity" refers to the coexistence of diseases. When patients with chronic mental illness age, they are at risk for the common disabling disorders of late life including arthritis, cardiac, and pulmonary disease.

These comorbid conditions or coexisting diseases can interact with each other. Medical illnesses can interfere with the strategies used by patients and caregivers to cope with mental illness, and mental illness can interfere with care for the medical illness. Comorbidity works in both directions. Patients with chronic mental illness are at risk for developing medical disease, and, conversely, patients with disabling medical illnesses are at high risk for depression and other psychiatric disorders.

"Excess disability" refers to the fact that patients often have multiple, interacting conditions, and that, even in the presence of irreversible causes of disability, there are often treatable components. For example, in a patient with irreversible self-care deficits due to stroke, there are often treatable problems such as depression and pain that increase or exaggerate deficits.

"Caregiver stress" is of concern because most care for elderly patients with chronic illness, mental or physical, is provided not by any public or private agencies or institutions, but by family members such as spouses, children, or siblings. Providing care can be a highly demanding and stressful activity, often competing with work or child-care commitments. This stress places caregivers at high risk for depression and physical health problems; the stress is so great, in fact, that it can lead to measurable deficits in the immune system. The caregiver is frequently the "second patient"; supporting the caregiver can be an investment that can help to maintain patients in the community and to prevent institutionalization.

Psychiatric disorders in late life differ in terms of "age of onset". Elderly patients with psychiatric disorders represent a combination of those with initial onset earlier in life and those for whom mental illness develops for the first time in old age. For patients with schizophrenia, manic-depressive illness, recurrent depressions and other disorders that began for the first time in younger adulthood, the course of the disease and the patients' care needs are affected by aging. For patients with Alzheimer's disease and related dementias, those with depressions occurring

as complications of chronic medical illnesses, and those with late-onset psychoses, psychiatric attention may be needed for the first time in late life.

Geropsychiatric Patient Populations

The elderly with chronic mental illness within the VA health care system consist of three groups of patients, each with its own needs.

Early Onset Patients Grown Old

Most apparent, perhaps, are the patients with psychiatric disorders with initial onset early in life who have now grown older. The aging chronic psychiatric patient is a significant problem, both within the VA system and in population at large. To recall, it was in the late 1950's and early 1960's that there were dramatic declines in the populations of state psychiatric hospitals as a result of the discovery of antipsychotic medications and the development of community treatment programs. Now, 30 to 35 years later, the first cohorts of chronic psychiatric patients treated within the community are becoming elderly. We are dealing with a new problem and the systems that exist may not be prepared to deal with it.

The needs of patients with chronic mental illness do not remain stable as they age. One component of change reflects the long term course of the mental disorders and the interaction between the disease and aging processes. Although there is an obvious need for additional research in this area, current findings suggest that some patients with schizophrenia exhibit an amelioration in their symptoms as they age, with new possibilities for rehabilitation and recovery. Clinically, therefore, there is a need to monitor elderly patients, not just with an eye to identifying new problems, but also new opportunities. There is also a need to make psychiatric rehabilitation programs available for elderly patients and to be willing to try again what may have been unsuccessful in the past. With manic-depressive illness, findings suggest that the frequency of episodes may increase and the time between them may decrease with aging and the

duration of disease. Older patients, even those who have been stabilized as younger adults, may require careful reevaluations of medications and more intensive treatment.

Another fact of life is that as patients age, so do their caregivers. We are all aware of middle aged or young-old patients who are cared for by their old-old and increasingly frail parents. Here, a common worry is what will become of the patient after the parents death. Spouses and siblings are also commonly involved in caring for and providing supports for chronic patients. With aging and their own diseases and disability, these caregivers can be less available, and, as a result the patient is at risk. One of the issues in the care of the aging chronic patient is, therefore, monitoring of support networks, with the need to modify formal services, at times by providing respite services, at others, day treatment or residential care, depending upon what happens within the patients informal system.

Finally, there are problems related to medical-psychiatric comorbidity. Nothing about having a chronic mental illness protects patients from developing the common medical disorders of late life, and, therefore, the aging of chronic psychiatric patients presents them and those providing their care with a new set of challenges. Providing medical care to chronic psychiatric patients is a difficult task, with barriers to the recognition and treatment of medical illnesses at the patient, provider, and institutional levels. A number of studies have documented the high prevalence of unrecognized medical illnesses among psychiatric patients. Recently Jeanne Cunningham, a nurse practitioner in our psychiatric outpatient department, reviewed her experience with medical evaluations of psychiatric patients and found that over 60% of elderly schizophrenic patients had no regular medical doctor and that the majority of them had one or more previously undetected medical illnesses. As the veteran population ages, maintaining chronic psychiatric patients in the community will increasingly require general medical as well as psychiatric services. For these patients, primary medical care is best provided by those who know the patient and can work with him. In this context, psychiatry is best conceptualized as a primary care discipline. Psychiatric

clinics should be equipped and staffed to provide basic primary care for chronically mentally ill patients with medical comorbidity.

Patients with Alzheimer's Disease and Related Disorders

A second population of geropsychiatric patients are those with Alzheimer's disease and related disorders. World War Two veterans are beginning to approach the age at which they are at greatest risk for the onset of Alzheimer's disease and related dementias. The popular press and much of the professional publications about Alzheimer's disease focus upon research findings, drugs under development, and possibilities for future treatment. As you know, the FDA's advisory committee has recently recommended approval of the first medication to be used specifically for treatment for Alzheimer's disease and approval of the drug is expected soon. However, as you also know, this drug will not solve the problem and many in the field have expressed concerns about the magnitude of the benefits demonstrated and about the risk benefit ratio. In general, there is a significant body of excellent research underway, through support from the VA, the National Institute of Health, the National Institute of Mental Health and other agencies. Although this research is critical, there is a need to emphasize what is known about the care of patients with Alzheimer's disease as well as what needs to be known. The VA should not place itself in a position of waiting for a breakthrough. While treatments are not available to prevent or reverse the cognitive deficits associated with Alzheimer's disease, established clinical interventions that treat excess disability can have profound benefits. Patients with dementia frequently have other disorders that represent reversible causes or treatable components of disability. For example, approximately 10% of patients evaluated for dementia have a component of their cognitive impairment as a result of an adverse effect of one or more medications. Approximately 20% have depression; 33%, delusions; 20%, hallucinations; and 40%, agitation or related behavioral disturbances. Thus, a large number of patients with Alzheimer's disease experience excess disability that can be identified and treated by geriatric psychiatry. To provide a measure of the significance of these established approaches to treatment, it has been estimated that approximately 10% of patients with Alzheimer's disease may benefit from the new drug tacrine, but the number of those who can benefit from

interventions designed to recognize and treat excess disability is far greater. While it is important to be hopeful and optimistic regarding the development of effective treatment for the cognitive deficits of Alzheimer's disease, it is necessary to realize that any methods of treatment will add to, rather than replace, existing approaches. There is a base of knowledge on current established treatment that warrants establishing Alzheimer's disease programs in all VA facilities. Moreover, having such programs in place will be necessary to optimize the cost effective use of more specific, probably more expensive, treatments to be developed in the future.

The VA has, in many ways been a leader in research and the development of clinical programs for patients with Alzheimer's disease. Many VA facilities have well-established programs for the evaluation and management of patients with Alzheimer's disease, but a large number do not. The full menu of service can include dementia evaluation programs, case management, counseling and support for caregivers, specialized medical services for the cognitively impaired, geropsychiatric impatient units for the acute care of patients with psychotic, affective, or behavioral symptoms, and nursing home care units designed specifically for the care of Alzheimer's patients. Such comprehensive services are rarely available and all programs have difficulty in moving patients between programs and levels of care when their needs change.

The most effective strategies for caring for Alzheimer's patients focus not just on the patient, but also on family caregivers by providing support groups, individualized counseling, and respite services as needed as well as psychiatric care for the patient. The value of this approach has been most convincingly established through recent research at New York University that demonstrated that these services can, on average, delay nursing home placement for Alzheimer's patients by 6-7 months. Thus, within a single-payor system active approaches to care targeting both the needs of the patient and those of the caregiver can provide both clinical benefits and cost savings.

Patients with Chronic Medical Illness

As emphasized in the recent NIH Consensus Conference on the Diagnosis and Treatment of Depression in Late Life, a third group of geropsychiatric patients are those with chronic disabling medical illnesses, complicated by psychiatric disorders, primarily depression. In fact, the majority of elderly patients with depression are never seen by mental health professionals. They frequently experience chronic mental illnesses only because potentially reversible disorders are not recognized or treated. My own research in this area has focused on depression as it occurs among elderly patients living in nursing homes. In these settings, approximately 25% of cognitively intact patients have a major depressive disorder and a comparable number have less severe, but nonetheless significant depression. In spite of the high prevalence, these depressions are often unrecognized or are dismissed as a natural reaction to institutional life. Research in this area, my own and that of others, has found that depression in the nursing home tends to be persistent, that it is associated with increased pain complaints, with biochemical markers for subnutrition, and with increased mortality. Moreover, when we conducted a double-blind study comparing the effects of a standard antidepressant with placebo, we found that depression in nursing home residents responded specifically to the active medication. Together these findings demonstrate that although depression in nursing home residents makes sense, it is, in fact, an illness that is associated with increased morbidity and mortality, and one that remains responsive to psychiatric treatment. Other investigators have studied the clinical features of depression as it occurs in association with cardiac disease, chronic obstructive pulmonary disease, Parkinsonism, stroke, and Alzheimer's disease, and the utilization and costs of health care services. Although there is a need for additional research, the available findings convincingly demonstrate that across a number of the most common chronic diseases of late life, depression is a common comorbid condition, and that it is associated with excess disability, and with increased utilization of general medical care. Most significantly, it is treatable.

While this discussion has focused upon depression, a similar case could be made regarding other psychiatric problems as they occur in general

medical care settings. These include anxiety disorders, substance abuse, and the need for active approaches for monitoring elderly patients to identify psychiatric side effects of drugs used to treat medical disorders. The conclusion to be drawn from this body of work must be that psychiatric disorders are common among all elderly patients with chronic illness, and that geriatric psychiatry services are needed in all chronic care settings.

Conclusions and Recommendations

Geriatric Psychiatry as a field is defined by a specialized body of knowledge regarding the mental disorders of late life. The field has become recognized as the second of the psychiatric subspecialties and approximately 1000 psychiatrists nationally have achieved added qualifications in this area. There is an obvious need for training programs to develop additional expertise in this area. There is also a need to complement the activities of specialists with those of general psychiatrists, nurses, social workers, and psychologists with training in the psychiatric disorders of the elderly. Clinical research is needed to further develop approaches to treatment for all elderly patients with mental disorders. However, current knowledge already demonstrates the value and the need for expanding programs.

The most basic recommendation must be that elderly veterans with psychiatric disorders have unique needs and present specific problems so that VA facilities should have specialized programs in Geriatric Psychiatry. These programs should include both designated units, outpatient clinics and inpatient programs, designed to provide specialized services as well as mechanisms designed to bring expertise in geriatric psychiatry to general medical services.

For elderly veterans with chronic mental disorders of early onset, geropsychiatric outpatient programs should include case management, as well as treatment and rehabilitative services. They should also provide basic primary medical care. Geriatric Psychiatry clinics can,

in addition, serve a similar coordinating and primary care function for patients with Alzheimer's disease and related disorders.

The need for geriatric psychiatry extends beyond traditional psychiatric care settings. By way of illustration, epidemiological research consistently demonstrates that, even when patients with chronic mental illness of early onset are excluded, the large majority of elderly nursing home residents have psychiatric disorders, primarily dementias or depressions associated with medical illness. Although based upon their patient populations, nursing homes are, in fact, neuropsychiatric institutions for the elderly, few are staffed accordingly. There is an obvious need to ensure that all nursing homes have programs in geriatric psychiatry. One type of special care unit may be of benefit for patients with Alzheimer's disease, and another, for those with chronic mental illness of early onset together with significant medical comorbidity. However, whether or not special care units are available, good clinical care demands that all elderly nursing home residents have access to geriatric psychiatry. Moreover, nursing homes are only the tip of the iceberg and psychiatric comorbidity is a major problem across all treatment settings for patients with chronic, disabling medical illness. Geropsychiatric consultation and treatment teams functioning across care settings can have a major impact on the VA system by reducing distress, excess disability, and excess health care costs for elderly veterans with chronic medical illnesses.

STATEMENT OF
JOHN T. FARRAR, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
ON VA CARE OF THE CHRONICALLY MENTALLY ILL
FOR THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

JUNE 29, 1993

Mr. Chairman,

Thank you for scheduling this hearing to review VA care of veterans suffering from chronic mental illness.

The VA medical system composed of 171 medical centers, 129 nursing homes, 35 domiciliaries, 302 outpatient clinics, 201 Vet Centers and extensive community based programs provides chronic psychiatric patients a full range and variety of levels of care. Day programs, sheltered workshops, intensive case management, specialized clinics, vocational training and rehabilitation, work with families and community caregivers, and a range of supportive living settings are but a few examples of the services available to eligible veterans.

While all of our medical centers offer some care for veterans with chronic mental illness, the larger tertiary centers and some thirty centers specializing in psychiatry and long-term care generally offer a wider range of mental health treatment and rehabilitation.

Since not all facilities can offer all services, we are developing a planning process by which VA establishes unique missions for each facility and encourages planning with both VA and non-VA providers in their shared geographical area.

The term, "chronic mental illness," actually can apply to patients with a variety of psychiatric disorders and can be looked at statistically from at least two perspectives. The first defines "chronic mental illness" as including patients in four diagnostic groups: Schizophrenia and Dementia, Other Psychosis, such as manic depressive illness and the major psychotic depressions; PTSD, and a Chronic Substance Abuse group. If we assume patients hospitalized for more than 90 days (180 days for the substance abuse group and over one day for PTSD patients) in one fiscal year have chronic conditions, in FY 1992, there were 33,950 patients with schizophrenic/dementia; 12,280 with

other psychosis; 20,320 with PTSD and 3,670 with chronic substance abuse for a total of just over 70,000 patients. Most of our cost studies derive from this system of classification.

We can also approach chronic mental illness from a diagnostic perspective. The largest and most challenging group of chronically mentally ill are those diagnosed with: 1) schizophrenia; 2) other major psychoses, and 3) dementia. These groups accounted for over 60,000 discharges in 1992. Of these 29,000 (48 percent) were diagnosed with schizophrenia, 23,000 (39 percent) with "other psychosis" and 7500 (13 percent) with dementia. Over half (52 percent) of these 60,000 veterans (31,000) were hospitalized less than 30 days; 5100 (8.6 percent) were hospitalized over a year.

While most of our care for chronic mental illness is delivered in brief hospital episodes, there is a significant population, including those under age 50, who are receiving more costly, longer-term care. There appears to be two, overlapping populations: a younger chronic population requiring treatment in-and-out of the hospital who require ongoing case management and rehabilitation; and a growing number of older patients, with "other psychoses" and dementia, who will require a different approach.

By the year 1999, veterans age 65 years or older are expected to number 9 million, and will remain in the range of 7.8 to 9 million until the year 2020. Although the reported prevalence of mental illness among the elderly varies, conservative estimates for those age 65 years or older include a minimum of 5 percent with Alzheimer's disease or other dementias and an additional 15 to 30 percent with other psychiatric illness. Today, in the Western Region alone, approximately 20 percent of all inpatients have a primary psychiatric diagnosis and more than 40 percent of these are over age 65.

Other psychiatric disorders can also be considered chronic for many patients. For a great many veterans, drug or alcohol dependency is considered a chronic, relapsing illness, not unlike diabetes or chronic lung disease. In FY 1992, substance abuse was the primary diagnosis for 62,000 inpatients and, over 189,000 VA outpatients were treated for these problems. Currently, VA is providing specialized inpatient and/or outpatient substance abuse treatment at

166 VA medical centers, domiciliaries, and freestanding outpatient clinics. VA hospitals have allocated 4,700 operating beds to these programs.

Post traumatic stress disorder, or PTSD, is now considered a chronic mental illness by many experts. VA treated over 20,000 individual inpatients with that illness last year, plus many more outpatients were seen in clinics, Vet Centers, and outreach programs. PTSD patients are seen at all of our medical centers, and across different clinical services. VA has established 20 specialized inpatient rehabilitation centers, eight PTSD brief treatment programs, three rehabilitation transitional housing programs and 57 PTSD clinical teams, providing consultation and outpatient care. Over one-third of veterans seen in the 201 Vet Centers are treated for PTSD.

It has been estimated that there are approximately 250,000 homeless veterans in communities across the country on any given day. Of those, approximately 40 percent are chronically mentally ill. Although all VA facilities provide some care to these veterans, VA currently operates 45 Homeless Chronically Mentally Ill (HCMI) programs and will add seven more in 1993. These programs have served 12,000 homeless veterans each year with over 3,000 receiving residential treatment. In addition, VA has funded 27 Domiciliary Care programs for Homeless Veterans providing rehabilitation and treatment for 3,000 veterans and 35 Compensated Work Therapy/Therapeutic Residence programs. In collaboration with the Department of Housing and Urban Development (HUD), VA provides staff for 19 sites offering ongoing case management and other needed assistance to homeless veterans in permanent housing supported by 600 specially-designated HUD rental assistance vouchers. VA has received $10 million for expansion of these programs in FY 1993.

The high prevalence of dual or even triple diagnoses in the majority of veterans with a chronic mental illness, makes the comprehensive nature of VA care especially valuable. Diabetes, hypertension, chronic lung disease, substance abuse, PTSD, and homelessness are common examples of coexisting conditions. We are beginning to see growing numbers of psychiatric programs focusing on the dual diagnosis patient.

In 1991, the Congress was generous in providing $6.0 million to enhance patient care in our long-term psychiatric facilities. Twenty-nine VA medical

centers which have played a special role in treatment of long-term mental illness have benefitted from this funding. Fourteen received funds for specialized programs directed specifically toward the chronically mentally ill, and the others have participated in ongoing educational and consultation activities. We are in the process of evaluating these programs and activities and will share the results when they are available. Allocating additional funding for underserved patient populations such as the chronically mentally ill, has made a difference.

We are limited in our ability to provide care to all veterans who could benefit from treatment. The increasingly restrictive funding environment for the entire system over the last five to ten years has indeed made our medical centers more efficient; however, most medical centers have been required to restrict access to care to veterans with the highest priorities for care. Current eligibility rules governing provision of outpatient care also restrict VA's ability to treat veterans with stable chronic conditions in the most appropriate settings.

We are not alone in limiting services. Many state hospitals and community mental health programs have felt the financial pinch and have drastically cut services that once served as alternatives to VA care. In the private insurance sector, mental health benefits have been severely restricted.

Although eligibility rules and funding limitations restrict both the continuum and quantity of care that we can provide, our goal is to provide high quality, comprehensive care to veterans who are admitted for care.

The answers to your specific questions, which we submitted prior to this hearing, address additional specific issues regarding chronic mental illness in veterans.

We again want to thank the Committee for scheduling this hearing to focus attention on the needs of veterans suffering with chronic mental illnesses. We will be pleased to respond to the Subcommittee's questions.

* * *

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JUNE 29, 1993

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to address the subject of the care and treatment afforded chronically mentally ill veterans by the Department of Veterans Affairs. In our opinion, this hearing provides an excellent occasion to promote the health care needs of this difficult to treat and too often neglected segment of our veteran population.

Based on site visits by our field representatives to VA medical facilities, we realize there is a problem with the treatment of the chronically mentally ill veteran and that some additional fiscal support and a renewed commitment toward the treatment of the chronically mentally ill veteran is necessary to provide effective remedies to ongoing concerns.

Prior to the past 10 to 15 years, very little in the way of alternative treatment modalities has been available through VA for the care and treatment of chronically mentally ill veterans. During the 1980s, VA began to develop residential care treatment programs for the care and treatment of chronically mentally ill veterans, along with compensated work therapy and activities of daily living programs. These programs were and still are unevenly applied throughout VA. Today there are approximately 35 VA medical centers which focus on care for chronic psychiatric patients, including two-division medical centers. Throughout VA, roughly 14,000 hospital beds are designated for psychiatric patient care. However, we are unable to ascertain how many of these beds are closed, how many are dedicated to acute care, chronic care and substance abuse patients.

Most chronic psychiatric patients are initially treated in an acute care setting. Then the referral mechanism between acute facilities, community resources, and VA long-term care facilities takes effect. Acute care facilities do their best in the initial assessment and treatment of patients, however, a breakdown often takes place within the referral process. Some VA facilities have not established effective liaisons with state and local community providers in the outplacement of chronic psychiatric patients. In some instances, this is the result of a lack of available community resources and in other cases a

lack of effective managerial leadership. We have witnessed more effective VA/community out placement programs in some extremely remote areas than in certain larger urban areas. The VA medical center in Knoxville, Iowa is an example of a very well managed psychiatric care program, which has developed a strong community presence in the care and rehabilitation of the chronically mentally ill veteran.

An additional factor in the care and treatment of the chronic psychiatric patient, is that non-service connected veterans often cannot receive care on an outpatient basis, due to current eligibility requirements. VA today is primarily accepting service-connected disabled veterans for outpatient mental health treatment. Also, due to a lack of available long-term psychiatric beds in VA, many patients end up occupying acute care beds long after their condition warrants a different level of treatment.

Mr. Chairman, during the mid-1980s, roughly $40 million was diverted from long-term psychiatric care programs to acute care treatment due to the introduction of diagnostic related groups (DRGs) within VA. The care and treatment of chronic psychiatric patients was ravaged by this action. Many psychiatric programs were downsized or eliminated due to this deed. Today, American Legion field service visits have confirmed some of our worse fears about the current state of chronic psychiatric care in VA. The following excerpts will highlight field survey findings over the past year:

VAMC Chillicothe, Ohio

This medical center proposes to activate 60 additional nursing care beds for the care of psycho-geriatric patients. The proposal is in response to patient demands and is consistent with the approved facility mission. The program is designed to treat chronically mentally ill patients who require extended care services and who are experiencing the frailties, functional disabilities, and chronic medical problems common to any aging population. These patients require nursing home care; however, their behavioral problems have made it very difficult to integrate them into a traditional VA or community based nursing home setting. Although not officially designated as psycho-geriatric nursing home beds, aging patients with primary chronic psychiatric diagnoses now occupy 180 of 212 nursing home beds at this facility.

The increasing number of psycho-geriatric patients has had a significant impact on the medical center. Longer lengths of

stay and lower turnover rates have resulted in a shrinking availability of beds. The lack of available beds has restricted our ability to accept psychiatric referrals from other network facilities and adversely impacted our ability to fulfill our mission as the long term care and chronic psychiatric referral center for the assigned network of VA facilities. Frequently, bed shortages have caused the inappropriate placement or retention of chronic patients on the wards. It also has limited access to care for new patients or patients needing readmission for acute care and required the initiation of a waiting list for extended care psychiatric patients.

VAMC Canandaigua, New York

This facility has developed a proposal to train nursing assistants as Therapeutic Advocates to provide paraprofessional support to psychiatric patients using a primary care model. This relieves registered nurses from being the primary care givers to patients that require the more complex and specialized nursing care.

The American Legion believes greater flexibility must be provided along the lines of this proposal to maximize personnel resources in the care and treatment of the chronic psychiatrically ill patient.

VAMC American Lake, Washington

There has been a considerable downsizing of the psychiatric bed program within the previous Resource Allocation model, in part, because the dollars were not there to support them. In 1983 there were still hundreds of long-term care beds, but these were reduced. Many of the patients remain in treatment programs, such as residential treatment. However, the pendulum has shifted too far the other way. Now, there are only 18 long-term beds for patients requiring inpatient treatment of six months or longer. This cannot accommodate what admissions are generated internally, much less those which should be accommodated by the facility as a referral resource.

VAMC Little Rock, Arkansas

Long-term care referrals are a problem throughout the VA system. We receive many long-term care referrals that we are not able to accommodate. In fact, we often have difficulty placing our long-term patients because of lack of nursing home facilities for patients with primary behavioral disturbances. The beds available for acute general psychiatry and the drug and

alcohol rehabilitation programs are adequate. There is a shortage of beds for chronic mentally ill patients throughout the VA system including this medical center.

VAMC Portland, Oregon

It lacks adequate resources to meet the long term outpatient care needs of local veterans with chronic mental illnesses who are indigent. For years, the staff has turned away NSC Category A applicants unless referred from our own inpatient services or Vet Centers. Non-VA community mental health clinics in Oregon are severely under funded and this situation is rapidly deteriorating because of property taxpayer revolt legislation. The lack of long term psychiatry inpatient care options is a serious concern.

VAMC Phoenix, Arizona

Long term care referrals are extremely limited. The designated referral facility for long term patients, VAMC Fort Lyons, Colorado, does not accept patients readily and requires a tremendous amount of time for transfers to be effective. No capacity exists to provide care to elderly psychiatric patients with medical problems or with psycho-geriatric conditions.

VAMC West Los Angeles, California

The psychiatric nursing home is the first in the VA system. The facility had 60 of 120 beds open at the time of the mid-1992 visit, because of staffing limitations. It has been recently reported that an additional 30 beds are now open for patient admissions.

VAMC San Diego, California

The medical center is badly in need of long term locked unit placement. Many of the veterans currently housed on the locked unit should be placed in a long term facility. There has been a placement problem on individual patients for many years. The hospital would greatly benefit from a day hospital for use of medicine, psychiatry and neurology patients. There is also a need for more nursing staff for patients who are medically ill as well as suffering from dementia.

VAMC Loma Linda, California

The facility has very limited resources for the referral of geriatric and chronically mentally ill patients. The

facility's long term care referral center, VAMC West Los Angeles, as reported, does not have adequate capacity to readily accept long term care referrals, due to a high occupancy rate and an increasing demand for services. As veterans age, more patients are seen with dementia and neuropsychiatric conditions. In California, public facilities are being downsized due to the state budget crisis. Consequently, VA is the provider of choice for veterans and often the only source of services.

VAMC Salt Lake City, Utah

Several actions are underway to alleviate the lack of referral beds for long term psychiatric patients. While it is unknown how productive these activities will be, the medical center will continue to treat the chronically mentally ill patients with available resources until other alternatives can be found.

The Chief, Psychiatry Service is negotiating with the State Mental Health System to improve accessibility of eligible patients to the state hospital. Additionally, the Mental Health Subcommittee of the Regional Planning Board is seeking to find mechanisms which will assist in providing additional long term psychiatric beds throughout the Western Region. Also, an initiative is being pursued by the veterans organizations for a Utah State Veterans Home.

Mr. Chairman, these illustrations represent a cross section of different types of VA facilities and the problems and concerns they are experiencing with regard to the care and treatment of the chronically mentally ill veteran. Some facilities have much more success than others. At the other extreme, some states have no VA long term care referral options. Among them is Florida, which has been planning to construct a long-term care psychiatric facility for the past 15 years. Around the country, the majority of VA facilities report similar problems concerning the lack of long term care resources and referral alternatives.

Mr. Chairman, there are no easy solutions to improving the care and treatment provided to chronically mentally ill veterans. The Legion believes the described problems will only become worse if effective solutions are not soon forthcoming. All too often, the chronically mentally ill veteran has no vocal advocates. Medical school affiliates are not interested in assuming responsibility for providing care, training, and education among this group of veterans. The care and treatment

of the chronically mentally ill veteran has not received the same attention as more high profile topics such as PTSD, homeless veterans, and substance abuse treatment. It is interesting to note that a chronically mentally ill veteran can receive more comprehensive care and treatment when they are homeless, rather than receiving appropriate care prior to their becoming homeless. Sometimes it is even extremely difficult to obtain timely medical/surgical consultations for this group of patients.

The American Legion believes that a revitalized attitude toward the care and treatment of the chronically mentally ill patient must be developed. An October 1986 market penetration study by the National Institute of Mental Health publication reported that of the veterans who seek treatment for mental illness in the United States, approximately 50 percent access the VA health care system. This finding could be due to the fact that private medical insurance for mental health conditions lacks comprehensive coverage. Although we cannot predict the future dynamics of psychiatric practice, we estimate that the demand for chronic psychiatric care in VA will continue to increase in relation to the aging veteran phenomenon and other factors.

Mr. Chairman, we believe the Veterans Health Administration must dedicate appropriate resources toward the care and rehabilitation treatment of the chronic mentally ill veteran. A certain percentage of these veterans will never be able to return to the community and will always be dependent on VA. However, a structured rehabilitation program, focusing on the quality and quantity of care required for successful reentry to a residential community setting, should be the treatment goal for this difficult to treat group of patients. The earlier the intervention in the treatment of certain mental illnesses, the better chance there is for a successful rehabilitation. In our view, VA must dedicate adequate resources to effectively treat chronically mentally ill veterans and develop dynamic rehabilitation programs.

Mr. Chairman, that concludes our statement.

NAMI

STATEMENT OF RICHARD T. GREER

MEMBER: SCIENCE REVIEW COMMITTEE, NATIONAL ALLIANCE FOR THE MENTALLY ILL; BOARD OF DIRECTORS, VIRGINIA ALLIANCE FOR THE MENTALLY ILL; VIRGINIA STATE MENTAL HEALTH PLANNING COUNCIL; ADVOCACY COMMITTEE (CHAIRMAN),ALLIANCE OF NORTHERN VIRGINIA;
ARLINGTON COUNTY COMMUNITY SERVICE BOARD

FORMERLY: U.S. ARMY AIR FORCE, WORLD WAR II;
STAFF DIRECTOR, REGIONAL & COMMUNITY DEVELOPMENT SUBCOMMITTEE, SENATE COMMITTEE ON ENERGY AND PUBLIC WORKS;
DEPUTY DIRECTOR, AND DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL ALLIANCE FOR THE MENTALLY ILL

BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS

June 29, 1993 - 9:30 A.M.
Room 334
Cannon House Office Building
Washington, D. C. 20515

NATIONAL ALLIANCE FOR THE MENTALLY ILL
2101 WILSON BOULEVARD, SUITE 302 • ARLINGTON, VA 22201
703-524-7600 • FAX 703-524-9094

Thank you Mr. Chairman. On behalf of 140,000 member families of the National Alliance for the Mentally Ill (NAMI) and NAMI Veterans Network, I take this opportunity to convey our gratitude for being invited to participate in this very important hearing. NAMI is a grass roots advocacy organization comprised of families of persons with severe mental illness as well as those persons themselves.

Psychiatric disorders are extremely expensive for the Department of Veterans Affairs (VA) and, therefore, to the U.S. taxpayer. Expenditures for VA mental health for the current fiscal year are $1.3 billion. Of this, at least $865 million is being spent on mental health services for veterans with schizophrenia and manic-depressive illness (also known as bipolar disorder). Thus, these two diseases alone consume two-thirds of the VA budget for mental health services because those afflicted are often substantially disabled and utilize a disproportionate share of inpatient and outpatient resources.

Schizophrenia and manic-depressive illness (the latter comprising the majority of the category described as "other psychotic disorders") together account for 71 percent of all veterans who are currently receiving 100 percent disability benefits for psychiatric disorders. The total annual cost for VA disability benefits for schizophrenia and manic-depressive illness alone is approximately $1.1 billion for those receiving 100 percent disability. If it is assumed that others with these disorders average 50 percent disability, that would be an additional $700 million in VA disability payments. The sum of the annual VA disability payments for schizophrenia and manic-depressive illness could therefore be as high as $1.8 billion. It follows then, given the magnitude of the VA expenditures connected to these diseases, the VA should increase its commitment to services research on persons with severe mental illness to identify the most economical and efficacious programs from the hospital into the community.

This message was conveyed by NAMI to the House VA-HUD Appropriations Subcommittee on May 6th, and, to Secretary Jesse Brown in a private meeting on June 16th. We were very pleased with the Secretary's request that NAMI follow-up with Dr. Paul Errera, VA's Director of Mental Health and Behavioral Sciences, with the expectation of integrating -- the successful community support concept of the Suncoast Community Support Auxiliary (an affiliate of NAMI) -- into the VA system.

The general image of the VA mental health system is one that is very traditional: heavily institution-based, and lacking in community-based programs for persons with severe mental illness. I believe this is changing, but very slowly. There are individuals in the VA such as Secretary Jesse Brown, Dr. Paul Errera, and others who are dedicated to moving the VA, in a more community-based direction congruent with 30 years of development of the U.S. mental health system as a whole.

The VA field research centers can play a major role in assisting this development by testing promising ways to organize, deliver and finance community care, as well as evaluating effectiveness and client outcomes. For example, the Northeast Program Evaluation Center (NEPEC) has been assisting in the development of programs of Intensive Psychiatric Community

Care (IPCC) at VA facilities around the nation; at last report, there were some 15 of these programs operating at VA hospitals. What NEPEC tries to do is outline principles of good community care that include intensive case management and a team approach. IPCC programs are linked by a monthly conference call in which, I am pleased to report, NAMI has been invited to participate, beginning in October of this year.

Mr. Chairman, language which was requested by NAMI is included in the Committee Report (#150) accompanying the FY 94 Appropriation Bill (H.R. 2491) recommending the National Institute of Mental Health (NIMH) and the VA should conduct joint meetings and submit a report (due prior to the FY 1995 hearings) outlining ways and means to improve the coordination of psychiatric research between the two agencies. Specifically, the report addresses the issue as to whether the use of beds in VA hospitals might be utilized more for NIMH clinical studies in order to reduce the overall cost of such studies.

I make reference to our previous suggestion to the Appropriations Subcommittee only because NAMI also strongly recommends to this Subcommittee that it encourage closer linkages between the VA and NIMH services research programs. The rapid build-up of these NIMH programs -- from 17 million in FY 1987 to $47 million in FY 1992, -- reflects the priority emphasis on research of community-based treatment for persons with severe mental illness including programs to assist successful transition of long-term hospital patients into their own communities.

Perhaps the most effective community service delivery model is the Program for Assertive Community Treatment or PACT. Supported since its inception in Wisconsin, in the late seventies, by NIMH, this aggressive outreach characterized by a team approach and intensive case management demonstrated benefits in independent living, social functioning, and employment status, as well as lower use of hospital inpatient services for persons with severe mental illness. It is the only full services program for persons with severe mental illness that has been tested in multiple clinical trails.

Mechanisms to facilitate greater collaboration between service delivery systems personnel and researchers should be encouraged. While the Public-Academic Liaison (PAL) program could be an important mechanism, it is directed to individual projects and not to the stimulation of a continuing collaboration. Therefore, NAMI recommends that the mechanism, for VA purposes, be expanded to permit the development of long-term collaborative arrangements between NIMH-based research in PACT and VA service systems personnel.

Mr. Chairman, therefore, research on services at these sites can and should be acted upon, utilizing the PACT concept, thereby strengthening the links between the veterans with severe mental illness and other components of mental health services in the community. The VA provides an ideal setting for psychiatric research on services because large numbers of individuals with these diseases are collected in one place. Of the 171 VA hospitals, for example, it is my understanding that 26 of them are primarily psychiatric.

Total, continuing, and cost effective health care for veterans with mental illness will be shaped by various factors including the structure of health insurance, housing, and social services regulated by various levels of government. In addition, voluntary programs dedicated to improving the quality of life for psychiatrically disabled veterans can prevent what often becomes an irrevocable break in the continuum of health care for some of these veterans. Effective mental health services require a full utilization of a range of these community support programs.

Family members are an important resource in the treatment of severe mental illness. Research overwhelmingly shows that when families are informed and take an active part in treatment decisions, consumer outcomes are better. In the case of veterans, an adoptive family advocacy concept needs to be encouraged. In these circumstances -- or where the mental health system is understaffed, under-financed, services uncoordinated, or other problems impede proper service delivery and integration into the community -- the adoptive family's involvement and advocacy is useful to assure the best possible treatment. Therefore, NAMI recommends a study of the community support concept using programs which have shown to be effective, e. g. the Bay Pines project[1], as models for implementation.

In summary Mr. Chairman, we recommend that the Department of Veterans Affairs conduct an internal review of its 26 psychiatric centers to determine what the range of community services and supports are needed to reduce rehospitalization and how these may best be provided. In addition to recommended joint ventures with NIMH and CMHS as part of that project, NAMI will devote full attention to working with our local Alliances in those areas, along with officials of the VA, NIMH, and CMHS in an effort to meet those needs.

1. See addendum regarding Suncoast Community Support Auxiliary.

DEPARTMENT OF VETERANS AFFAIRS
Medical Center

Doug Hall, Bay Pines VA Medical Center CSG Coordinator nominated SUNCOAST COMMUNITY SUPPORT AUXILIARY, INC. for President Bush's THOUSAND POINTS OF LIGHT AWARD AND RECOGNITION, January 1993, as follows...

Introduction

The Suncoast Community Support Auxiliary, Inc. (SCSA) is a non-profit charitable and educational organization dedicated to improving the quality of life of psychiatrically disabled persons and their families. SCSA began in 1985 as a group of family members of veterans in the Community Support Group (CSG) Program at the Bay Pines VA Medical Center who met with staff to discuss the ramifications of mental illness within families. Family members pooled their resources, volunteered to help and in 1987 incorporated under state law as a charitable non-profit organization. Today the Auxiliary has a membership of over 90 individuals and families. The Auxiliary is recognized as a volunteer organization by Bay Pines Voluntary Service and is affiliated with the National Alliance for the Mentally Ill (NAMI). The Auxiliary is funded by voluntary dues and support of the CSG and veterans in the community.

Achievement

SCSA publishes a monthly newsletter on mental health topics. Now in its 86th issue, the newsletter contains articles by staff, consumers, and family members to educate, inform , and enhance communication between consumers, families and staff. SCSA maintains an extensive mailing list and sends out over 400 newsletters each month.

The SCSA Visitation Program provides social and recreational activities for veterans in the hospital and the community.

The SCSA Telephone Committee provides the simple but crucial service of telephoning consumers, families and others to convey important information quickly, respond to urgent needs of CSG members, and recruit volunteers for various CSG activities.

The SCSA annually organizes a banquet and graduation ceremony for graduates of CSG's independent living skills classes. Graduates are given diplomas and awards for meritorious achievement.

The Annual CSG Picnic and the Winter Party are joint efforts of SCSA and CSG consumers. Approximately 200 consumers, family members, VA staff and persons from the community attend each of theses events annually.

A major long term goal of the Auxiliary is the establishment of a community Drop-In Center for CSG veterans. A large portion of the Auxiliary's donations and annual dues is held in reserve as seed money for the Drop-In Center.

Community Needs

Chronic mental illness is highly stigmatizing and debilitating affecting the entire family and the community. Persons with chronic mental illnesses need supportive services in addition to psychiatric treatment to live and function in the community with dignity. Families need information, support, and opportunities to participate effectively and appropriately in the treatment of mentally ill family members. Through its social, educational and networking activities, the SCSA helps meet these needs for veterans and their families.

Innovation

SCSA is unique: a voluntary association of veterans and family members organized to support and enhance a mental health treatment program. SCSA brings together veterans, families, and VA staff in a cooperative effort to promote mutual understanding and high quality services. SCSA provides a vital supplement to the limited resources of the CSG.

Mobilization

SCSA is continually striving to expand its services and provide opportunities for others to volunteer. New members and volunteers are always welcome and encouraged to be as active as possible.

Ongoing Involvement

Started in 1985, SCSA is still going strong today and looking to the future. SCSA's activities are carried on throughout the year and SCSA members are in continuous contact with consumers, families, and staff.

Department of Veterans Affairs

PSYCHIATRY SERVICE

Certificate of Appreciation

Presented to

SUNCOAST COMMUNITY SUPPORT AUXILIARY, INC.

This award is presented by Psychiatry Service, Bay Pines VA Medical Center, to the members of the Suncoast Community Support Auxiliary, Inc. in recognition of their selfless dedication and invaluable contributions to the veterans within Psychiatry Service.

Through its monthly newsletter, visitation program, telephone committee, and graduation banquet, but mainly through the tireless devotion and generosity of its members, the Auxiliary provides a vital supplement to the limited resources of the Community Support Group. Without their efforts our program would not be as successful as it has been.

For approximately 8 years the Community Support Auxiliary, with their cooperative effort, has brought together veterans, families and VA staff to provide mutual understanding and a high quality of mental health care to veterans in Psychiatry Service.

Ali Keskiner, M.D.

Ali Keskiner, M.D.
Chief, Psychiatry Service

May, 1993

Vietnam Veterans of America, Inc.
1224 M Street, NW
Washington, DC 20005-5183

(202) 628-2700
(202) 628-5880 fax

In Service to America

STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented by

William F. Crandell
Legislative Advocate

Before the
House Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

on

VA Care of the Chronically Mentally Ill and Alternatives to Long-term Care

June 29, 1993

TABLE OF CONTENTS

DISCUSSION

Mr. Chairman and members of the Committee, Vietnam Veterans of America (VVA) is pleased to have the opportunity to present its views on the important topic of VA care of the chronically mentally ill, with special attention to VA's use of alternatives to long-term care. Your foresight in addressing alternatives is particularly impressive to us, Mr. Chairman. The staggering costs of long-term care in mental health reach far beyond the damage they do to budgets. Veterans who find no help short of long-term care suffer terribly, as do their families. When men and women cannot stay at home and at productive jobs because of psychiatric difficulties, the loss to our economy is also significant.

This is a complex subject, one that involves more than tallying beds and asking for more staffing. VVA will discuss several aspects of the issue. The first will be VA mental health care in a national health care setting. The second will be the mental health care aspect of the VA's general problem of quality of care. The bulk of our testimony will focus on Post Traumatic Stress Disorder (PTSD), the greatest and least understood chronic mental health problem addressed by the VA today. In considering how PTSD is handled and how it <u>needs</u> to be handled, we will discuss what needs to be done with the one existing alternative to long-term care that has had such significant success to date, the Vet Center program, and its relationship to the rest of the VA. We

shall also examine the in-and-out nature of PTSD patients, and the ongoing need to correct VA's bias against claims for compensation of PTSD, which results in much higher utilization of long-term care than is necessary.

VA MENTAL HEALTH CARE IN THE AGE OF NATIONAL HEALTH CARE

Perhaps the most challenging issue facing the organized veterans community right now is the shape VA health care will take once some form of national health program is adopted. The outcome of that debate will have a major impact on care of the chronically mentally ill.

Will such reform open the doors of both private and state facilities to patients who now have no option other than VA care? As we noted in our testimony of April 28 of this year before this Subcommittee, the two leading health reform designs are "managed competition" and "single payer" programs. Of these, "managed competition" is the design President Clinton has embraced.

The VA can ill afford to ignore any longer the fact that the advent of national health care offers veterans currently dependent upon VA the first hope of exercising choice in deciding where to secure health care. Like other consumers, veterans will go for care where they can most conveniently be treated in a manner meeting <u>their</u> expectations of quality. This will be no different

for the chronically mentally ill, whether they are capable of making their own decisions or these choices are made by family members.

THE QUALITY OF VA MENTAL HEALTH CARE

Under either "managed competition" or "single payer," it is clear enough to us that many veterans currently dependent upon the VA for health care would opt out of VA if a more accessible option with perceived higher quality were available. For the chronically mentally ill veteran user of the VA health system, quality is best defined as being seen at appointments on time by courteous and competent professionals, being subject to a minimum of invasive procedures designed to satisfy teaching needs and by being reasonably assured of timely and successful treatment. The consensus of veteran users of all forms of VA health care -- right or wrong -- is that quality is deficient.

There are a variety of things the VA does as well or better than the private sector. These include long term mental health care, substance abuse treatment, outpatient treatment of PTSD through Vet Centers and even inpatient PTSD treatment in those hospitals which are serious about treating PTSD. These programs should be expanded through bed conversion. Legislation mandating bed conversions using a phase-in mechanism should be developed and enacted once the specific shape of a national health program

becomes clear.

POST TRAUMATIC STRESS DISORDER TREATMENT AND RESEARCH

Post Traumatic Stress Disorder is perhaps the major contributor to chronic mental illness among veterans of any generation. According to the highly respected National Vietnam Veterans Readjustment Study (NVVRS), published in 1988 by the Research Triangle Institute, nearly half a million men and women who served in Vietnam suffer from full-blown PTSD. It is a chronic disorder in itself, not limited to Vietnam veterans but attacking those who served in every war, as well as people who have experienced a wide variety of other traumatic stresses. NVVRS found those with PTSD likely to experience other specific psychiatric disorders. Although many veterans with PTSD have not yet sought treatment, they are more likely to seek VA care than veterans who do not suffer this disorder.

THE NEED FOR NEW LEGISLATION ON PTSD

The importance of enacting legislation to broaden VA treatment of PTSD is that so little has been done by the VA of its own accord to address the magnitude of the PTSD epidemic. Similarly, it is critically important that veterans with PTSD who are treated in VA

general psychology or psychiatry inpatient, outpatient or other clinics lacking expertise in PTSD be treated for the proper disorder. Today no such guarantee of proper treatment exists.

VVA would endorse legislation that recognized the research already done on this issue and embraced improvements in access to service and modalities of treatment. Passage of such legislation would move the VA closer to acceptance of a medical mission to provide the range and type of PTSD care that is presently lacking in both the VA and private sectors.

As we noted in our April 28th testimony, the VA is treating only about 10% of those veterans whose military service resulted in PTSD, whether this service occurred during or before the Vietnam War, in Operation Desert Storm, or in the day-to-day routine of military operations. Not only has the demand for program services been ignored by VA in the past, but the success of those existing programs have often been threatened by "departmental reorganization" efforts and funding cuts. The most recent example is that of the Vet Center program. In addition, specialized PTSD services, like that of VA health care in general, are sparse and may be located at an inaccessible distance from the veteran.

Even when the veteran is able to access VA care, PTSD is often misdiagnosed. VA needs to recognize and implement procedures to ensure that veterans needing PTSD care are recognized properly and

treated appropriately. Far too frequently, the VA looks at PTSD and sees instead only the substance abuse that is so often a telltale symptom of PTSD, branding the symptom "willful misconduct" and refusing to diagnose the disorder itself. And the notion that PTSD, where it is detected, is not service-connected, but merely the outgrowth of some hypothetical childhood instability, is still too prevalent in a veterans health care system that has been seeing veterans return from war for half a century with these symptoms.

Vietnam Veterans of America is proud of the leadership role we have taken in the long twilight war to gain understanding and treatment for veterans with PTSD. In recent years this Committee has grown to have such an understanding, and we want to thank you for the actions you have supported thusfar.

The VA is only beginning to recognize that women can be affected by PTSD, too. One step that still needs to be taken is the adoption of legislation which calls for broadening the context of service-connected Post Traumatic Stress Disorder to include the aftermath of sexual trauma. And as more women flow into the military, whether or nor their combat roles are expanded, they have already begun swelling the ranks of veterans with service-connected stress problems. The general shortage of VA readiness to accommodate women patients in the VAMCs is reflected in psychiatric facilities as well.

The study at the Boston VAMC's Women's Health Science Division on the effects of PTSD on women veterans' mental health and physical well-being appears to be a serious step in the right direction. The study aims at improving the assessment and treatment of PTSD in women veterans. In addition, it will train the medical staff in PTSD. Sadly, many VAMCs still need such training.

In terms of chronic care, we would support legislation to increase access for all war-time veterans to appropriate care within the VA by expanding and improving current specialized PTSD treatment units, and by providing additional research into modalities of treatment. It has been suggested that the expertise of the National Institutes of Mental Health and the Center for Mental Health Services be integrated. Furthermore, such a bill would encourage health professional specialization in PTSD under the VA Health Professionals Scholarship Program and allow VA provision of counseling services to veterans' families through the Vet Center program.

Inpatient PTSD units operated by the VA, of which there are only 20 system-wide at present, must be increased by another 30 such units within the next four years. In addition to this, so as to assure proper treatment of PTSD in VA facilities lacking inpatient PTSD units or nearby Vet Centers, the number of PTSD clinical teams (PCTs) should be increased by 50 over four years;

there are currently only 57 PCTs.

In addition to the increase in Specialized Inpatient PTSD Units (SIPUs) by 30 units over the next four years, Congress should provide authorization for an additional number of the smaller inpatient units that VA has designed to provide care for those awaiting openings in SIPUs (Evaluation and Brief Treatment Units; currently, there are 8-9 units) and post-SIPU adjustment (Residential Rehabilitation program; currently there are 10 units). The number of these units should be tripled with incremental steps stipulated over the same four year period.

Finally, the importance of creating statutory authorization for the Advisory Committee on Readjustment of Veterans has become vital just this year. The Committee is a viable sounding board for consumer recommendations on the VA PTSD and readjustment programs. As a result of President Clinton's recent Executive Order terminating all non-statutory advisory committees, this program is on the chopping block, and needs to be preserved.

Chronic PTSD is widespread and has associated disorders such as depression and substance abuse. Dual-diagnosis also complicates the treatment process. Awareness needs to be raised throughout the Veterans Health Administration of the symptoms and proper modalities of treatment for PTSD. Ranging levels of treatment are necessary to provide a continuum of care for individual veterans at

varying levels of recovery. These program levels are and should continue to be mutually supportive, so that care and counseling are provided at whatever level is appropriate and accessible.

ALTERNATIVES TO LONG-TERM CARE OF CHRONICALLY MENTALLY ILL VETERANS

The best alternatives to long-term care for the various forms of chronic mental illness related to PTSD and other major mental illnesses are early treatment and outpatient care. For many 100% mentally-disabled veterans, full-time institutionalization is neither necessary nor desirable. Although some patients may never be released, others are in and out of VA facilities, "going in" when the stress of their daily lives compounds their problems, and, in intervals, living fairly normal lives after periods of treatment.

The Vet Center program, operated under the aegis of VA's Readjustment Counseling Service (RCS), has done remarkably successful work over time to keep veterans out of long-term institutional care for PTSD. A model of user-friendliness, the Vet Centers have provided individual and group counseling that have given thousands of veterans treatment that has eased their problems before they needed inpatient care.

The need for the Vet Centers has increased since the war in

the Persian Gulf. *A 1992 Walter Reed Army Institute of Research study shows that 28% of the cases involves seeing dead bodies, and 15% derive from fears of Scud missile attacks. What is important about these stressors is that they do not apply only to "front-line" troops. The potential for a massive influx of Desert Shield/Desert Storm veterans with PTSD is serious. Early treatment through the Vet Centers can keep most of those cases from becoming serious.

READJUSTMENT COUNSELING SERVICE AMENDMENTS OF 1993

What early treatment of PTSD will require is both an expansion of the Vet center program and a recognition by Congress and the VA that RCS is not a temporary administrative structure. We are seriously interested in legislation that is currently being drafted under the title Readjustment Counseling Service Amendments of 1993, which will accomplish those aims. It is time to go beyond the biennial rallies to save the Vet centers, and to recognize that the alternative is an epidemic of chronic mental disorders stemming from PTSD that will give not only the VA budget but the rest of the nation's social services a frightening burden.

HONEST VA COMPENSATION AS AN ALTERNATIVE TO LONG-TERM CARE OF CHRONICALLY MENTALLY ILL VETERANS

Though it does not come under the purview of this subcommittee, there is one other clear and obvious alternative to long-term care of chronically mentally ill veterans: compensation. VVA has again and again described the ongoing need to correct VA's bias against claims for compensation of PTSD, which results in much higher utilization of long-term care than is necessary.

PTSD-disabled veterans whose disability compensation is lower than it ought to be are subjected to a variety of current-day stresses that exacerbate their conditions. These include feelings of anger and injustice, anguish over how real their unrecognized symptoms are, and -- most important -- stresses around finding work that will support them. No blinded or legless veteran rated 100 percent disabled is required to be unemployable to receive compensation, but the effect of denying such a rating to PTSD-disabled veterans where merited means that they must ignore their disabilities in the workplace.

The VA's refusal to rate disabilities for PTSD at comparable levels to physical injuries seems a last vestige of the infamous incident of General George S. Patton slapping a soldier with fatigue-induced tears during a visit in which the visionary commander himself wept at the physical injuries of his other soldiers. This bias for visible disabilities is a vestige of the military's age-old assumption that any health problem that cannot be seen is malingering. It has no place in modern medicine, nor in

honoring the losses of America's warriors, especially in the light of the NVVRS finding that for every two soldiers in Vietnam who suffered physical wounds, three were subject to clinical level PTSD.

Nowhere did more offensive evidence of this VA ratings bias show up than in the recent testimony before two House subcommittees on health problems and claims problems of Persian Gulf War veterans. As witness after witness related stories of the VA not only denying that their physical ailments were service-related, but that they were being given 10-20 percent ratings for PTSD, a clear pattern emerged. Any other PTSD claim demands evidence of the traumatic stress from which PTSD springs, stress that was absent in many of these cases. Assessing low levels of PTSD without proof establishes in their files a presumption that these younger veterans are unbalanced complainers. This pattern makes it clear that VA still considers PTSD a "junk disease," a bogus whine of some sort.

Minimizing these biases and fairly compensating these veterans is the best guarantee against having to provide long-term care to veterans who could be rehabilitated instead. VA's hostile, tough-guy, pinch-penny ratings for PTSD save nickels and cost millions of dollars at best, or save nickels and waste lives at worst. It would be worth asking whether any veterans advocate attending this hearing does not know of at least one veteran who decided that

suicide was the only alternative to lifelong struggles with the VA over claims for compensation or lifelong institutionalization, because surviving on a 50 percent PTSD rating and a handshake was impossible.

THE NEED FOR A BLUE-RIBBON PANEL ON THE VA AND PTSD

VVA would like to see a blue-ribbon panel created to take a deeper look at how VA handles -- and should handle -- cases of PTSD. Such a panel needs to cross VA's administrative boundaries, and find the failed connections between the Veterans Health Administration and the Veterans Benefits Administration with regard to PTSD. Why do so many PTSD-disabled veterans qualify for so much in-patient care and such low compensation ratings? Why does Vocational Rehabilitation pay them so little attention, when so many of them can hold decent jobs? Why, when a PTSD-disabled veteran recovers sufficiently to be given a lower compensation rating, doesn't the VA automatically contact that veteran to provide help in finding work that will make up for the resulting income loss?

Mr. Chairman, chronic mental illness -- whether from PTSD or any other condition -- must be recognized as chronic, as an affliction whose effects may ebb and flow without going away. A patient need not be in constant crisis to merit a high disability rating. Tunnel vision in the VA's quickness to downgrade benefits

is never matched by its speed in upgrading them, and that demonstrates a bias that does not have the veteran at its heart. This bias is too expensive in human lives and taxpayer dollars to condone it. We owe both physical and metal injuries the same deep respect, the same competent care and the same fairness in adjudications.

Mr. Chairman, this concludes our testimony.

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE VA'S CARE OF THE CHRONICALLY MENTALLY ILL

INCLUDING THE STATUS OF VA'S

USE OF ALTERNATIVES TO LONG TERM CARE

JUNE 29, 1993

Mr. Chairman and Members of the Subcommittee, on behalf of the Members of Paralyzed Veterans of America (PVA), I wish to thank you for inviting us to testify today concerning VA's care of the chronically mentally ill, including the status of VA's use of alternatives to long-term care of such patients.

The VA health care system has over the years tailored certain services to the specific needs of veteran patients to a degree for which there is no comparable counterpart in the private medical sector. The VA Mental Health and Behavioral Sciences Service is typical of such a service. Other examples include Prosthetics and Rehabilitation, Spinal Cord Injury, Blind Rehabilitation, Geriatrics and Long Term Care.

The sheer volume of mental health workload and wide variety of programs exceed what reasonably could be absorbed by public and private providers should the VA system ever be discontinued, or its services diminished, in the course of national health care reform. It is in anticipation of the impact on the VA health care system from most scenarios for health care reform that characteristics of the VA Mental Health and Behavioral Science service take on special meaning.

For this reason it is imperative that in anticipation of enactment of national health care reform that the unique VA role

and function providing mental health services for veterans be clearly defined. The Congress should enact legislation providing entitlement for all Core Group veterans (consisting mainly of the service connected and medically indigent veterans) to receive the full continuum of mental health services beyond the current inpatient care limitations. This entitlement reform should give both veterans and providers the benefit of a broader mix of treatment alternatives - ambulatory care, halfway house and other forms of non-institutional rehabilitative services - to provide more cost effective and efficient treatment modalities.

According to the National Institutes of Health, over fifty percent of all veterans in need of mental health services receive that care through the Department of Veterans Affairs (VA). In recent years approximately 40 percent of all the 3 million individual patients seen annually in the VA system are veterans with mental health disorders, and account for some 20 percent of all VA outpatient visits. Nationally, VA appears to provide about 36 percent of all veteran hospitalizations in psychiatry.

It is unlikely, under any national scenario of health care reform, that the basic medical benefit insurance package would provide anything approximating what the mentally ill veteran receives in the VA, in either volume or variety. Nor would most non-indigent veterans have the financial means to avail themselves of what psychiatric care is offered outside the VA system.

Aside from the psychoses, VA behavioral services also deal with multiple psycho-social disorders for which veterans as a group are at high risk, particularly homelessness, substance abuse and post-traumatic stress disorder (PTSD). These conditions often feed on each other, and providers must coordinate responses to best treat the underlying causes of the veteran's disorder. Commendable progress has been made toward progressive increase in non-institutional workload for these programs and serve as an example of VA full potential for other types of ambulatory care.

A short reference is made to the success of those psycho-social disorder programs and a concern that perhaps the pendulum of resource commitment needs to shift in a manner to achieve comparable prevalence of non-institutional venues for care of the chronically demented and other long term psychiatric patients.

The Homeless Chronically Mentally Ill (HCMI) program was begun in 1987 and since that time the VA has had contact with approximately 10,000 veterans per year. VA estimates that from one-third to one-half of the nation's homeless are veterans, that the number of homeless veterans could be as high as 250,000 and that two-thirds of that number are likely to be drug or alcohol addicted. VA also states that up to 45 percent of those enrolled in the HCMI have serious medical conditions. Veterans who need psychiatric and medical care are aided through VA clinics and community-provided rehabilitative services.

Even more spectacular has been the success of the PTSD program for which the Congress has also been heavily committed through specified incremental appropriations. The National Vietnam Veterans Readjustment Study claims that approximately 500,000 Vietnam-era veterans need treatment for this disorder, with unknown numbers from other wars.

The non-institutional options so successful in both of the above programs could be repeated for other types of mental illness. Unfortunately, because of the perversity of current entitlement rules, the majority of the Core Group veterans cannot be offered out-patient care. As a result they are either provided more expensive hospitalization or, more often, denied access to VA care altogether. This is but one glaring example of the need for entitlement reform.

There are already established limited modalities of outpatient care for mental illness - including ambulatory clinics, adult day care centers, and home care. However, the same imbalance exists, tilted toward institutional psychiatric care, as is present in

general medicine and surgery programs - not only in the VA, but to a lesser degree across the nation's health care industry. Eighty cents of each dollar spent by the VA on mental illness goes to inpatient modalities of care. VA has made a start on this shift of venue, but far short of what is required if it is to earn the opportunity for a place in tomorrow's competitive medical market. To meet acceptable standards of efficient and economic delivery of care, much more emphasis, including capital investment, needs to be placed on ambulatory programs for the chronically mentally ill veteran.

Although the total number of veterans is slowly declining, recent studies by VA staff indicate that the use of psychiatric services for veterans will increase. This is due to the fact that cohorts currently demonstrating high-use of psychiatric services are advancing into age groups with even higher utilization patterns. For example, Vietnam era veterans, who have demonstrated high use rates, will be using even more services as they age. It is in the aged that mental illness reaches the highest incidence. Whereas current projections indicate an overall decrease in the number of veterans with service needs for psychiatric inpatient care, the new projection methods indicate an increase in the requirement for psychiatric and nursing home beds concomitant with significant decreases for surgical and medical beds.

If priority listing were ever made of the various VA medical care services, long term care, in all of its aspects, deserves a primary mission identification.

The VA health care mission itself is changing and this must be recognized in the upcoming reform of the nation's health care system. Under certain reform scenarios attractive alternate sources of care for veterans may well reduce the VA acute care workload in medicine and surgery, but the demand for VA delivered care in both geriatric and mental illness will increase unabated. Long term ambulatory and institutional chronic care, including

especially that for psychiatric patients, will consequentially consume a greater proportion of the VA health care dollar in the future. A similar phenomenon will occur in the private health care industry although, intensity-wise it is a decade behind that seen in the VA system.

Recognizing this should make policy makers aware that the demand for VA services in the future preclude it from being an effective competitor in an exclusively acute health care arena under national health care reform. Far more promising is the concept whereby VA places its principle focus on those specialized services at which it has historically excelled while providing the acute multi-specialty clinical support commensurate with the specialized services' ancillary health care requirements.

RECOMMENDATIONS

- Enact veterans entitlement reform to mandate full continuity of care, with special emphasis on expanded out-patient venue, for all Core Group veterans.

- Provide incremental appropriations for expansion of VA plant facilities designed for ambulatory medical programs.

- Provide the staffing and resource enhancements for 30 existing long-term psychiatric care facilities.

- Provide 150 additional homes for therapeutic residences for veterans' industries programs and provide these programs as joint ventures with non-profit entities.

- VA should expand its nationally recognized expertise in geriatric medicine by supporting residencies and fellowships in no fewer than 10 VA medical centers.

PVA notes that much of the above described developments together with the pertinent recommendations for VA realignment were also contained in the Strategy 2000 report, *The VA Responsibility in Tomorrow's National Health Care System*.

Mr. Chairman, I thank you for this testimonial opportunity and would welcome any questions.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA CARE OF THE CHRONICALLY MENTALLY ILL

WASHINGTON, D.C. JUNE 29, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for affording us this opportunity to testify with respect to the Department of Veterans Affairs' care of the chronically mentally ill. Given that a significant number of this nation's veterans are suffering from post-traumatic stress disorder (PTSD) as well as other mental disabilities incidental to their service in the United States Armed Forces, the VFW commends the chairman and members of this subcommittee for holding this hearing today. Although the wounds of these brave men and women may not be physically apparent, the pain is nonetheless real and they certainly deserve all the help a grateful nation can provide.

Mr. Chairman, the Department of Veterans Affairs' psychiatric programs indeed serve a unique segment of the veterans population. These programs are often without peer within the private sector. Furthermore, VA psychiatric programs serve patients who would have little or no access to mental health services outside the VA system. In fact, mental health services make up an extremely sparse percentage in some of the most comprehensive private-insurance packages. Veterans who are less likely to have adequate coverage are even less likely to have adequate financial access to mental health benefits.

Although veterans are vulnerable to all the psychiatric disorders found in non-veterans, they are at particular "high risk" with respect to homelessness, substance abuse, severe psychosis, and post-traumatic stress disorder. These conditions often feed on each other and

75-468 O - 94 - 5

providers must coordinate responses to best treat the underlying roots of the veteran's psycho-social disorder.

VA, like other psychiatric providers that care for the chronically mentally ill, relies heavily on custodial care. Caring for this population's basic needs is essential. Without the programs provided by VA, chronically mentally ill veterans often lacked food, shelter, or adequate clothing. Alcohol or drug use is often a substitute for rehabilitation to alleviate the veteran's pain and confusion.

In addition to the important custodial care these facilities offer veterans, VA runs programs which rehabilitate mentally ill veterans and allow them to regain their independence. Along with 30 VA medical centers specifically designated as long-term psychiatric care facilities, VA administers intensive psychiatric community care programs, psychiatric transition wards, adult-day care centers, and mental hygiene clinics. These VA programs often successfully rehabilitate mentally ill veterans and allow them to regain their independence. One of the most important aspects of these programs is that they encourage development of independent living skills for the less impaired veteran who might otherwise be "warehoused". Unfortunately, due to budgetary constraints, there are waiting lists for enrollment in these programs. We believe VA should establish short-term care settings with more intensive therapy to augment its services to the chronically mentally ill. In order for VA to better serve the chronically mentally ill, we believe it should develop innovative psychiatric care programs in less restrictive settings and expedite veterans return to the community.

Mr. Chairman, one of the most shameful statistics indicate that from 1/3 to 1/2 of our nation's homeless are veterans -- mostly Vietnam-era service persons. VA itself estimates that the number of homeless veterans could be as high as 250,000. Many of these veterans are mentally ill and exhibit compounded problems. Substance abuse often accompanies these mental illnesses and, by some estimates, 2/3 of VA's homeless patients are treated for addiction to drugs or alcohol. VA has

stated that up to 45 percent of sampled veterans enrolled in homeless chronically mentally ill programs have also serious medical conditions.

One area of concern is the fact that VA may be releasing mentally ill patients from medical facilities too soon or not providing the patient with adequate support facilities. While many veterans respond well to treatment within a long-term psychiatric care facility, it is just as important that they continue their medication in a consistent manner when discharged. In many cases, this is not happening. The veteran either ceases to take his medication or, in some cases, sells or trades his medication in order to purchase alcohol or non-prescribed drugs. The end result is a rapid deterioration of the progress attained as a patient in a long-term psychiatric care facility. VA should expand homeless veterans programs that focus on enhancing a veteran's independent living skills. Expansion of programs such as drop-in centers, compensated work therapy/therapeutic residence programs, domiciliary care for homeless veterans programs, VA supported housing programs, and comprehensive homeless centers should receive serious consideration.

Mr. Chairman, another serious problem manifesting within the veteran's community is post-traumatic stress disorder. This has become increasingly prominent in the 80's and 90's. The National Vietnam Veterans Readjustment Study, which the Research Triangle Institute conducted, found that 15.2 percent of the 3.4 million Vietnam-era veterans may experience PTSD. Also, according to this study, approximately 500,000 Vietnam-era veterans may respond to treatment for PTSD. Currently VA administers several programs for veterans suffering from post-traumatic stress disorder. These include post-traumatic stress disorder residential rehabilitation programs, POW support groups, joint post-traumatic stress/substance abuse disorders units, and readjustment counseling.

While Congress has been sympathetic to the needs of veterans with PTSD by adding funding for PTSD in-patient/out-patient care programs, research, PTSD clinical teams, and a PTSD national center, VA must continue its progress in treating veterans with PTSD. Persian Gulf war

after-effects may compel those veterans with recent combat experience to seek help; VA must target eligible veterans and address their specific needs.

Mr. Chairman, the VFW believes VA has made great strides in its treatment programs of the chronically mentally ill. Its research role in the treatment of the chronically mentally ill is highly respected and considered essential by experts in the field. In fact, the VA's research capability is so well regarded that the National Institute of Health contributes financially and materially to its efforts. Considering the resources VA has been provided, they are doing an excellent job. However, it has to be noted that considering the work load facing VA, they are still under funded and under staffed. While nursing staff levels have slightly improved, there is still a shortfall in the intensive care and the critical skill level. While funding is, of course, critical to the success of any program, the care of the chronically mentally ill relies solely on dedicated professionals committed to treating the needs of a highly deserving and vulnerable component of the veteran population. Recruitment and retention of these highly specialized health care professionals must be established as a priority within the Department of Veterans Affairs.

This concludes my statement. I will be happy to answer any questions you may have.

TESTIMONY BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS, U. S. HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING

BY

CHARLES S. PRIGMORE, Ph.D.

NATIONAL JUNIOR VICE COMMANDER

AMERICAN EX-PRISONERS OF WAR

WASHINGTON, DC JUNE 29, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE.

I AM PLEASED TO APPEAR BEFORE YOU TODAY AND TO OFFER THE THINKING OF THE AMERICAN EX-PRISONERS OF WAR ON VA CARE OF THE CHRONICALLY MENTALLY ILL, INCLUDING THE STATUS OF VA'S USE OF ALTERNATIVES TO LONG-TERM CARE OF SUCH PATIENTS.

THE PRIMARY EMPHASIS IN THE VA WITH CARE OF THE CHRONICALLY MENTALLY ILL HAS BEEN LONG-TERM HOSPITAL CARE, ALTHOUGH THERE HAS BEEN A SECONDARY EFFORT TO PLACE THE CHRONICALLY MENTALLY ILL IN COMMUNITY PLACEMENT HOMES AND GROUP HOMES. A PROMISING NEW DEVELOPMENT IS THE PROVISION OF SUBSIDIZED HOUSING FOR HOMELESS CHRONICALLY MENTALLY ILL.

OUR PRIMARY RECOMMENDATION IS THAT THE VA RECEIVE FUNDS TO EXPAND ITS USE OF COMMUNITY PLACEMENT HOMES, GROUP HOMES, AND SUBSIDIZED HOUSING FOR THE CHRONICALLY MENTALLY ILL. WE ALL REALIZE THAT EXTENDED HOSPITAL CARE INEVITABLY RESULTS IN LOSS OF INDIVIDUAL SELF-WORTH, PRIVACY, COMMUNICATION SKILLS AND ORIENTATION TO REALITY. HOWEVER, SINCE SOME HOSPITAL CARE WILL CONTINUE, WE RECOMMEND BETTER TRAINING FOR PERSONNEL.

ON THE OTHER HAND, RELEASE OF CHRONICALLY MENTALLY ILL VETERANS TO THE COMMUNITY WITHOUT PREPARATION, PLANNING, ASSURANCE OF SUITABLE HOUSING AND CONTINUED SUPERVISION RESULTS IN A STRONG LIKELIHOOD OF ACTING OUT BEHAVIOR, INABILITY TO COPE AND EVEN SUICIDE.

COMMUNITIES NEED TO BE ASSURED THAT THE VA WILL MAINTAIN PROFESSIONAL SUPERVISION WHEN A VETERAN IS PLACED IN A COMMUNITY PLACEMENT HOME OR RESIDENTIAL CARE HOME, AND THAT THE SPONSORS OR CARETAKERS ARE THOUGHTFULLY SELECTED AND HELPED TO HANDLE PROBLEMS THAT WILL ARISE. SOME TRAINING OF SPONSORS DOES TAKE PLACE, BUT IT NEEDS TO BE EXPANED AND STRENGTHENED.

WE BELIEVE THAT THE PRESENT COMMUNITY PLACEMENT HOME SYSTEM, RELYING FINANCIALLY ON PERSONAL FUNDS OF THE VETERAN SHOULD

BE SUPPLEMENTED BY HIRING AND TRAINING PEOPLE TO LIVE IN VA-OWNED HOUSES AND CARE FOR 4 - 8 CHRONICALLY MENTALLY ILL VETERANS. SUCH AN ARRANGEMENT WOULD ENABLE THE VA TO DEVOTE MORE TIME TO TRAINING AND SUPERVISING THESE CARETAKERS. CHRONICALLY MENTALLY ILL VETERANS WITHOUT ADEQUATE PERSONAL FUNDS COULD BE PLACED IN SUCH HOMES. AN ALTERNATIVE TO THIS ARRANGEMENT WOULD BE GREATER USE OF THE GROUP HOME, ALSO CARING FOR 4 - 8 CHRONICALLY MENTALLY ILL VETERANS. HERE, HOWEVER, THE FINANCIAL SUPPORT WOULD HAVE TO COME FROM PERSONAL FUNDS OF THE VETERAN.

WE ARE CONCERNED THAT EVEN IF THE COMMUNITY PLACEMENT HOME AND GROUP HOME SYSTEM ARE GREATLY EXPANDED, WHICH IT SHOULD BE, THAT A NUMBER OF CHRONICALLY MENTALLY ILL VETERANS WOULD BE LEFT OUT IF THEY LACK SUFFICIENT PERSONAL FUNDS. I CHECKED WITH ONE VA MEDICAL CENTER, WHICH TAKES $655.A MONTH FROM THE VETERANS PERSONAL FUNDS TO PAY FOR FOSTER CARE. MANY VETERANS DON'T HAVE $655. A MONTH. MOREOVER, MANY CHRONICALLY MENTALLY ILL VETERANS ARE TOO EMOTIONALLY DISTURBED TO BE PLACED IN NORMAN COMMUNITY PLACEMENT HOMES. THEY ARE HARD TO CARE FOR IN THE COMMUNITY. SPONSORS (CARETAKERS) WOULD NEED TO BE ESPECIALLY WELL-TRAINED AND SKILLED TO CARE FOR SUCH VETERANS. IT IS STILL TRUE, HOWEVER, THAT SOME CHRONICALLY MENTALLY ILL VETERANS WILL NEED HOSPITAL CARE FOR AN EXTENDED PERIOD OF TIME.

ANOTHER VIABLE ALTERNATIVE FOR SELECTED CHRONICALLY MENTALLY ILL VETERANS IS THE USE OF HOMEBOUND CARE IN THE PATIENTS OWN HOME WITH VA SUPERVISION.

IN SHORT, WE NEED TO EXPAND THE VA ALTERNATIVES TO LONG-TERM CARE, SUCH AS EMPLOYING MORE STAFF TO DEVELOP AND SUPERVISE COMMUNITY RESOURCES AND EXPANDING THE SYSTEM OF COMMUNITY PLACEMENT HOMES, GROUP HOMES AND SUBSIDIZED HOUSING.

A FINAL NOTE, IT SHOULD BE EMPHASIZED THAT COMMUNITY RESOURCES LIKE FOSTER CARE OR EVEN SUBSIDIZED RESIDENTIAL CARE ARE FAR CHEAPER THAN HOSPITAL CARE, IN ADDITION TO BEING A FAR MORE HEALTHY AND CREATIVE ENVIRONMENT.

UNIVERSITY OF MARYLAND
AT BALTIMORE

DEPARTMENT OF PSYCHIATRY
John A. Talbott, M.D., Chairman
410 328 6735

July 29, 1993

J. Roy Rowland, Chairman
Subcommittee on Hospitals & Health Care
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Cong. Rowland,

In answer to your query "Would you amplify on your proposal that VA design "models" for treating special populations?"

What I meant was that the VA, because it has a higher concentration of mentally ill veterans with specific co-morbid problems such as PTSD, alcohol and drug abuse and physical trauma, could issue an RFP for VAMC's to purpose different models of care for these populations and then measure outcome and economic differences between and among them. Thus, as it did with its multi-site cooperative Day Hospital and Psychopharmacology studies, the VA could establish successful models for the nation in areas where they have strength and patient concentrations.

Sincerely,

John A. Talbott, M.D.
Professor & Chairman

/vpb

Institute of Psychiatry and Human Behavior
645 West Redwood Street, Suite F1008
Baltimore, Maryland 21201-1549
410 328 4695 FAX

Department of Veterans Affairs
Veterans Health Administration

PRE-HEARING QUESTIONS FOR HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON
CHRONICALLY MENTALLY ILL VETERANS
June 29, 1993

Question 1: Of VA dollars devoted to mental health care, please approximate the ratio of dollars devoted to ambulatory vs. inpatient care. Are there State mental health systems that devote a higher percentage of their mental health funding than VA to ambulatory (vs. inpatient) care? If so, please provide such data.

Answer: In the last four fiscal years the percentage of VA mental health funds allocated to outpatient care has ranged from 18 percent to 20 percent with no obvious trends.

State mental health agency expenditures in FY 90 averaged 38 percent allocated to community-based programs. Wisconsin ranked first with 73 percent outpatient care. All but three states (Iowa, Kansas and Nebraska) ranked above the VA's 20 percent. The largest state program, California, spent 66 percent on community programs.

Question 2: Please identify any financial or managerial incentives for medical center directors to shift resources from hospital care to outpatient alternatives, particularly in the area of chronic mental illness.

Answer: The Mental Health and Behavioral Science Service has put greater emphasis on outpatient services in their distribution of funds to support new PTSD treatment, substance abuse treatment and homeless programs. Additionally, in FY 1992 the initial funding document (Target Allowance) specifically withdrew funds from hospitals with large inpatient workloads and provided funding to medical centers which emphasized outpatient workloads.

Question 3: Of funds for VA bed care, what percentage of total funding is devoted to psychiatry bed care?

Answer: The funding for the Psychiatric bed sections in 1992 is estimated to be twenty percent of the total funding for all VA hospital bed sections.

Question: Of the funding devoted to VA psychiatric bed care, approximately what percentage of that funding serves acute vs. chronic care?

Answer: We define a chronic care patient as one who has been hospitalized for more than 90 days a year in the past 4 years with a diagnosis of schizophrenia, dementia or "other psychosis" VA data show $617 million (50.5 percent) expended for chronically mentally ill patients in psychiatric beds out of a total $1.221 billion for all psychiatric inpatients.

Question 4: Other than those VA programs (including "vet centers") which are targeted to veterans who are homeless or who suffer from post-traumatic stress disorder or substance abuse problems, at how many VA facilities has VA established programs through which the Department provides or "case-manages" community-based rehabilitative services to chronically mentally ill veterans? Of that number, how many such programs include provision of supportive housing?

Answer: An exact census of programs as defined in this question is not available. However a survey of mental health programs at all VA medical centers performed in May 1992, reveals the following breakdown of community-based programs relying heavily on case management:

Compensated Work Therapy (sheltered work, often including individual case management)	68
Crisis Intervention	39
Halfway house on VA grounds (usually using a case management approach)	4
Intensive Psychiatric Community Care	10
Psychiatric Hospital-based Home Care	5
Psychogeriatric Adult Day Health Care	11
Total	137

Because some medical centers have more than one of the above 137 programs, the total number of medical centers involved is only 96.

A significant number of these programs provide some support regarding housing and are combined with the programs noted in question 6.

Question 5: Approximately what is the current census of VA's long-term psychiatry beds? Approximately what is the total census of community-based beds which VA maintains, operates, or provides through contract arrangements targeted to providing transitional housing and rehabilitative services for chronically mentally ill veterans, exclusive of programs targeted to veterans who are homeless or suffer from substance abuse disabilities and exclusive of the personal care residence arrangements where veterans bear the expense of their housing?

Answer: At most VA medical centers, psychiatric beds are not classified as either long or short-term. Some of our larger primarily neuropsychiatric medical centers do make that classification locally, but those beds do not reflect the national picture. Chronically mentally ill patients with long lengths of stay may be seen on general psychiatric wards, in intermediate medicine, in VA nursing homes and in domiciliaries. Using the definition of chronic mental illness noted in question 3; however, we can estimate that out of a national VA psychiatric bed census of 12,604 in FY 92, 6332, or 50.2 percent, were being used for chronic mentally ill patients.

We have no way of approaching an accurate bed census of VA funded community beds. However, the 1992 survey of all VA mental health programs reveals the following:

Psychiatric Residential Rehabilitation and Treatment Programs (funded by VA)	4
Psychiatric Community Transitional Housing (not funded by VA)	10
Community Half-way Houses not funded by VA but with VA staff attending	4
Total	18

These 18 programs report treating 513 patients in residence during the month prior to the survey.

Question 6: It is our understanding that workload projections or forecasts were developed as one element of the Resource Planning and Management (RPM) process. Relative to FY 1992 levels, what workload did the RPM task force project VA would experience nationally for chronic mental illness in developing its RPM projections for FY 1994? What are the funding implications of such projections?

Answer: In the RPM information system, all patients with significant psychiatric illness are classified into one of seven groups. Among these seven groups, there are four chronic mental illness groups: other psychosis, PTSD (Post Traumatic Stress Disorder), schizophrenia and dementia, and a chronic substance abuse group. Patients in these groups have been hospitalized for psychiatric care for more than 90 days (180 for the substance abuse group) in one fiscal year over the past four years. The patient information on these patients are kept in a registry and all of their costs (inpatient, outpatient, long-term care, acute care and non-VA care) are accumulated. These data are rolled-up from VA medical centers.

The RPM workload projections arise from a series of mathematical forecasting techniques, the results of which are reviewed at the national, regional, and facility level. The RPM workload projections are now in the early stages of review with the regional offices and field facilities. This review will not be completed until mid-July. The unadjusted initial RPM projections which are currently under review show an increase of 0.7 percent in chronic mental illness workload nationally for FY 1994 relative to the FY 1992 levels. The final estimated increase associated with the chronic mental illness workload projections for FY 1994 will not be known until after the RPM process is completed in August. Over the next several weeks, facility directors, regional directors and VA central office staff will be involved in reviewing, negotiating and adjusting FY 1994 workloads and resources at the local VAMC level. The Budget Planning Review Committee is scheduled to review the budget implementation plan in late June and it will subsequently be presented to the Under Secretary for Health for approval.

Question 7: With respect to FY 92 workload levels, please provide any available data regarding the percentage of veterans furnished VA or VA-funded care for chronic mental illness who are service-connected for such illness.

Answer: The total percent of individual veterans residing in or discharged from VA funded facilities in FY 1992 who were treated for a service-connected chronic mental illness is 31.6 percent (22824/72126). For the subgroup with organic psychoses (including dementias) the percentage is 11 percent (1368/12424; for schizophrenia the percentage is 46.4 percent (15287/32944); and for "other psychoses" the percentage is 23.0 percent (6169/26758). The percentage of patients with schizophrenia stand out as the largest group and the one most likely to be service-connected. These figures include veterans in, or discharged from, VA medical centers, non-VA medical centers receiving VA funds, VA domiciliaries, VA nursing homes, and VA-funded community nursing homes.

Question 8: Please confirm our understanding that there are data regarding "market penetration" which indicate that some 50 percent of all veterans with psychiatric problems receive care for those problems from the VA. What percentage of veterans use VA for needed medical and surgical care?

Answer: A Mental Health Statistical Note No. 179 by the National Institute of Mental Health, dated October 1986, states, "Of the approximately 1.2 million persons admitted for inpatient psychiatric care during 1980, 312,969, or 23 percent were U.S. military veterans. Fifty-one percent of these veterans were admitted to Veterans Administration medical centers (VAMCs); 23 percent, to non-Federal general hospitals; 20 percent to State and county mental hospitals; and 6 percent to private psychiatric hospitals..." A series of 1986 tables by NIMH showing Veteran Status of Persons Under Care report that:

"VA Medical Centers accounted for...

"48 percent of the total number of veterans under [inpatient] care on April 1, 1986 in [and] ... 55 percent of the total number of veterans admitted to the inpatient programs ...

"45 percent of the total number of veterans under [outpatient] care on April 1, 1986, [and] ... 26 percent of the total number of veterans admitted to the outpatient programs ... [and]

"57 percent of the total number of veterans under [partial] care on April 1, 1986 [and] ... 23 percent of the total number of veterans admitted to the partial care programs

...of specialty mental health organizations nationwide."

Using internal data, we estimated that the VA market penetration for psychiatry and substance abuse is approximately 30 percent. The corresponding figure for medicine is slightly more than 17 percent and for surgery is slightly less than 17 percent. These figures were derived by dividing the VA census for each program by the estimated total veteran demand by program. Total veteran demand is assumed equal to the veteran population multiplied by the male private sector use rate.

Question 9: It is our understanding that many VA mental health clinics and day programs are no longer accepting "category A" nonservice-connected patients who are otherwise eligible for outpatient treatment and are limiting new patients to those who are service-connected. Please confirm the accuracy of our understanding. If accurate, please comment on the degree to which such far-reaching limitations with respect to NSC (nonservice-connected) "category A" veterans have been imposed in other clinical programs and on changes which would be needed to provide such access to these nonservice-connected veterans.

Answer: We do not have data to compare relative access to care on a diagnosis basis; however, no category of nonservice-connected veteran has statutory eligibility for unlimited mandatory outpatient care of chronic conditions.

Title 38, U.S.C. Section 1712 (a)(2) provides for mandatory outpatient care to nonservice-connected veterans whose annual income does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 1521(d) of this title. However, the care which can be provided under this authority is limited to medical services reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission. In the case of a nonservice-connected veteran who has been furnished hospital care, nursing home care, or domiciliary care, care is limited to medical services reasonably necessary to complete treatment incident to such care.

Question 10: What percentage of VA education and training funding for medicine, surgery and psychiatry is allocated to psychiatry? Please provide data on the relationship between the allocation of funds for training residents in psychiatry and VA workload (measured by patients treated) as compared with the allocation ratios applicable to medicine and surgery.

Answer: The percentage of VA training funds that was allocated to residents in academic year 1992-1993 was 51 percent in general internal medicine, 36 percent in surgery, and 14 percent in psychiatry. However, in comparison with the total number of residents in the U.S. excluding specialties not supported by the VA, only 7 percent were in psychiatry nationwide.

The following table shows the ratio of patient discharges to residents in VA medical centers with residency training programs, in academic 1992-1993.

Patient Discharges	Residents	Discharges/ Resident Ratio
Psychiatry		
112,712	754.5	1:49
General Internal Medicine		
335,618	2747.3	1:22
Surgery		
217,289	1888.7	1:15

The above data pertains only to VAMCs that have residency training programs (N=136). It should be noted that factors other than workload enter into the process of resident allocation such as the quality of the education program.

Question 11: Please comment, and provide supporting data, on the view that there exists a shortage of psychiatrists nationally as well as within VA.

Answer: From the national perspective, a report of the Graduate Medical Education National Advisory Committee (GMENAC) published in 1983, projected a shortage of 8,500 general psychiatrists by 1990, based on projected need for 37,000 to 40,000 psychiatrists. According to testimony of the American Psychiatric Association (APA) before the Subcommittee on Physician Manpower of the Council on Graduate Medical Education (COGME) in February 1991, the academic community responded to the GMENAC report by increasing the overall number of psychiatrists per 100,000 population during the 1980s, "although recent supply trends may eradicate those gains." (A GOGME report in 1992 reported, "In the late 1960s 10 percent of medical students chose psychiatry residency training. This dropped to 4.5 percent in 1991 and fell further to 3.7 percent in 1992.") This report notes also, "There is a shortage of psychiatrists who care for the elderly mentally ill. As the population ages this shortage will become even more severe." The APA testimony concludes, "... there is little disagreement about the existence of a shortage, but the usefulness of a specific number based on mediocre data is questionable." The APA recommends, "Additional trainees are especially needed in child psychiatry, geriatric psychiatry, treatment of substance abuse disorder, care of the most severely and chronically mentally ill, and psychiatric research."

We have no absolute standards to define "shortage." A panel on psychiatry which studied four VA medical centers in depth for the 1990 Institute of Medicine report on physician VA staffing concluded, (page 267), "In all four, the current FTEE level was significantly below the FTEE level derived using the SADI [an externally derived rating scale]. At least two of the four ... are severely understaffed. The panel believes that the finding emerging from this small-sample study fairly reflect the state of psychiatry staffing in the VA, but it would be premature to draw conclusions about the overall extent of understaffing in each of the facilities across the system."

The number of vacant VA positions at a given facility is defined as the number funded minus the number filled. Since the number of funded positions reflects a decision made by local management of what is needed and fundable, the vacancy rate reflecting "shortages" may give information on unfilled positions locally, but are not an indication of any standardized supply and demand ratio. Vacancy rates also reflect a shortage due to recruitment

difficulties which, in turn, could be a function of an inadequate national supply as well as the relative attractiveness of VA positions vis-a-vis alternatives.

The vacancy rate varies over time and with the method of gathering data. Probably the most accurate information was obtained by a special questionnaire sent to all VA medical centers in May 1992, which had 100 percent compliance and was signed by each medical center director. This survey revealed a total psychiatrist FTEE (full time equivalent) of 1,657 (including both full and part time positions) with a vacancy of 265 FTEE or 16 percent. This survey occurred approximately ten months after the physicians' pay bonus was enacted. A survey in February 1991, by Chiefs of Psychiatry with approximately 90 percent compliance, also revealed an overall vacancy rate of 16 percent; however, vacancy rates in some of the more rural, neuropsychiatric facilities reached as high as 35 percent.

Another approach from a Survey of Physician Vacancies reported to VA Personnel Service by specialty, with full- and part-time positions counted as individuals, records 203 psychiatrist vacancies in FY 1989, increasing to 263 by the first quarter of FY 1992, and dropping to 207 by the end of FY 1992. These trends are consistent with impressions from field psychiatrists that the rate was increasing rapidly until the physicians' pay bonus came into play and that their ability to recruit psychiatrists has improved considerably since then, particularly at the non-affiliated medical centers.

We conclude that shortages of psychiatrists most evident in primarily non-affiliated, rural, neuropsychiatric facilities is still acute, but that the physicians' pay raise has eased the recruiting job overall.

Question 12: Please provide any available data on cost variations among VA medical centers in treating patients with chronic mental illness.

Answer: VA medical centers vary dramatically in terms of size, scope and complexity of health care delivered. Authorized beds range from 40 to 1,105. We have highly affiliated tertiary care centers; small, rural, primary care facilities; 13 two-division medical centers; many general hospitals; 29, primarily rural, medical centers focusing on large chronic psychiatric and medical populations; and a wide range in between. This range is not unlike the non-VA medical sector.

CMI (Chronic mentally ill) patients are seen in 160 medical centers and 7 independent clinics. Using FY 1992 RPM (Resource Planning and Management) data, the numbers of CMI patients seen at our facilities range from 3200 (Miles City) to 53,000 (Houston). Excluding VA independent outpatient clinics, annual costs per case-mix adjusted work units for CMI patients range from $2,562 to $6,567. The average cost for this group is $4,295 with a variation among medical centers of $2,707 (about half).

The average costs per person for CMI patients with a schizophrenia or dementia diagnosis is $40,209; higher than CMI patients with a chronic (over 180 hospital days in a year) substance abuse diagnoses ($33,945); an "other psychosis" diagnosis ($31,599); or a PTSD diagnosis ($8,916). Regional cost differences mirror the private sector with Region 1, the northeast, being the most expensive and Region 4, the west, being the least expensive. Thus, costs vary due to size, location, case-mix, severity, mission, geography, salary differentials, and practice style.

Question: 13: It is our understanding that a survey of VA's 29 neuropsychiatric medical centers was conducted recently at VAMC Ann Arbor in connection with a congressionally funded initiative on enhancement of long-term mental health care. What were the findings of the survey with respect to medical care of psychiatric patients? What else did the survey reveal?

Answer: The Medical Care Resources Survey revealed that on average, medical services provided 2.4 (range 0.5 - 5.0) physicians (FTEE) per 50 medical inpatients while psychiatry services provided 1.8 (range 1.1 - 3.5) psychiatrists (FTEE) per 50 psychiatric inpatients, a 25 percent difference. While both medicine and psychiatry, on average, provided only 0.3 FTEE physicians per 50 inpatients across services (i.e., internists spending time with psychiatric patients), the range was 0.01 - 1.0 for medical coverage of psychiatry and 0 - 1.6 for psychiatric coverage of medical patients. Thus some medical centers may provide adequate in-service and cross-service coverage, while others provide inadequate inpatient medical staffing.

Problems regarding obtaining support services was limited to long waiting periods for CAT (Computerized Axial Tomography) scans at some medical centers, and difficulty transferring patients requiring specialized medical care to tertiary VA facilities.

QUESTIONS SUBMITTED BY
HONORABLE J. ROY ROWLAND, CHAIRMAN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS

HEARINGS

CARE OF THE CHRONICALLY MENTALLY ILL

JUNE 29, 1993

Questions for Dr. Errera

Question

Please provide the Committee your personal and professional view as to the dynamics by which VA could practically and most effectively realize a shift from its heavy reliance on inpatient care of the chronically mentally ill to noninstitutional care. Please advise us regarding the length of time over which such a shift should occur and the assumptions made in offering that projection.

Answer

This sounds like a simple question, but it is not. You are not merely asking what would it take for VA to improve some of its programs. You are asking, I believe, what it would take for VA to realize its potential to be the best public mental health system in the country. I am not exaggerating. Consider this question with me. What would be a mental health system planner's dream? Dr. Talbott exhorted us a few weeks ago to develop integrated systems of care like the Robert Wood Johnson Foundation did in nine U.S. cities. The ideal system envisioned by Dr. Talbott would be a system in which psychiatric, substance abuse and medical care were all delivered together; a system in which chronically mentally ill patients would not be stigmatized, but rather would share in a public identity of which they could be proud, not ashamed. It would be a system in which financial benefits would be fair and generous and fully integrated with the health care system; in which patient advocacy groups are well-known, polite, highly responsible and readily available to help patients use and improve their health care system. It would be a system in which services were available anywhere you might go, across the entire country. The ideal system for chronic psychiatric patients that Dr. Talbott dreams of, and that I have just described does not need to be created -- it exists and it is the VA health care system.

The aspiration of all community psychiatrists and mental health planners for over 30 years has been to develop a humane system of care for chronically mentally ill persons in the community. I maintain that we can create this system in VA. We already have the foundation and the scaffolding and many of the walls. But, you will naturally ask, "Well, if you can create this system, why haven't you done it yet? What's stopping you?" The answer is simple. It has not been a priority. It has just not been a priority. Let me give you an example. Five years ago, with the help of yourselves and many others, we set up a small demonstration program in intensive psychiatric community care for our sickest patients. We don't have the final results of the evaluation, but we do know that overall the program saved over $4,000 per patient per year and that their symptom levels were significantly lower than matched patients who didn't get treated in the new program. This program works and if disseminated nationally, it would be an important step towards implementing state-of-the-art psychiatric care in VA.

In the last four months, one of these programs had to be closed. Why? Because the medical center didn't want to operate it as a community program, but rather wanted to use the staff to support workload in one of its standard clinics. In the last week, I have gotten two calls about other programs that want to move staff from these special teams to other parts of the medical center. Why would this happen? Two simple reasons. First, change never comes easily. People are inclined to do things the way they have always done them.

If you are used to an institution-based service system, you're inclined to stick with that kind of system. But perhaps more important is the fact that these patients and their programs, while recognized and accepted as a presence in VA, are not a priority in VA. The main dynamic involved in the change you ask about, is the shift from a presence to a priority. That's what it would take.

To return to your original question, establishing a community-based system of care involves three major issues: 1) we must evaluate our actual need of inpatient care services. Although medical services in our country are generally over-bedded, psychiatric services in the public sector have been continuously cut back. As state systems have cut back their mental health services, more and more veterans are coming to VA for psychiatric care. We may need the beds we have; 2) we must disseminate well established community care models throughout the VA system. Such dissemination will require extensive staff training and monitoring of the implementation of new activities. Community-focused care represents a substantial change from past practices. Change in a system the size of VA will come slowly and only with persistent, and committed leadership; 3) we must set up satellite clinics so that veterans who live some distance from VA medical centers can have access to convenient sources of outpatient care. We have developed models of integrating such satellite clinics in local mental health centers, and we need to find other ways of facilitating the integration of VA and non-VA community care systems.

Question

In your opinion, do most VA medical facilities offer as broad a continuum of care for the mentally ill as for the medically ill patient?

Answer

This is a bit like comparing apples and oranges. While medical patients have diverse needs because of their different illnesses and needs for different procedures, psychiatric patients have very broad needs because of the breadth and depth of their functional deficits. Most VAMCs offer a continuum of care for psychiatric patients that is generally similar in its overall breadth to that of medical patients. But the continuum of care for psychiatric patients is (or should be) broad in different ways. While the medical continuum must include emergency rooms, outpatient clinics, radiology services, surgical services and many other types of technical care, psychiatric programs must address issues ranging from acute psychiatric treatment through halfway house treatment, family conflicts, and social supports, vocational rehabilitation, housing and access to financial benefits and jobs.

Question

Many categories of veterans are limited under law to outpatient treatment to "obviate a need for hospitalization." In your professional opinion, what does that term mean in the context of psychiatric treatment? How can one know that a failure to provide outpatient treatment for a schizophrenic will not trigger a need for hospitalization? Doesn't the unpredictability of psychiatric illness argue that treatment is needed to "obviate a need for hospitalization?"

Answer

The question embodies the response that we have been making to this situation for many years now. You are quite correct in presenting the rationale that providing outpatient care, in the long run, prevents the need for hospitalization. This is the rationale that is used in many medical centers, by clinicians who are committed to doing the right thing for their patients.

I am not a lawyer, but it seems that even a moderately cautious reading of the law suggests that it actually refers to an imminent need for hospitalization, not an hypothetical need in some remote future. The law as it stands hardly suggests that VA places a priority on sustained community care for its psychiatric patients. Rather, it implies that outpatient care can only be provided to prevent imminent hospitalization. Although most clinicians exercise a liberal view of this law, it would be far better if the law more explicitly encouraged that the right thing should be done, rather than merely allowing it through a back door.

Question

In your professional opinion, is there the same need to alter priorities in funding VA research regarding mental illness as there is to alter funding of medical care? Or would a shift in medical care funding to psychiatry programs tend to stimulate more research into mental illness?

Answer

There is a need for additional funds for psychiatric research, especially in the development of new systems of care for the severely mentally ill. We have new medicines and new diagnostic tools, but these do not get to as many patients as they should. We must determine who is underserved and find ways of providing them with the services they need. Increased funds alone, however, will not accomplish this task. Rather, there is a need to harness the psychiatric research effort of medical schools (and others if necessary) to the organizational goals of VA. To do this, we must develop special research initiatives that will either attract expert researchers in this area to VA, or that will help them train current VA staff in research techniques.

Questions for Dr. Farrar

Question

In response to pre-hearing question #6 regarding workload projections associated with the Resource Planning and Management (RPM) process, the Committee was advised that "initial RPM projections" would call for a 0.7% increase in chronic mental illness workload nationally. Given estimates that demand for VA mental health care would increase significantly, what is the basis or bases for a projected increase of less than 1%? Please identify the final workload projections for FY 1994 (relative to the FY 1992 level) for chronic mental illness. Have RPM workload projections for "CPG class patients" or for chronic mental illness been shaped or revised at all by reference to national policy direction or decision? If so, please explain.

It is our understanding that certain "national policy decisions" were made to guide implementation of the RPM process. Please identify those specific national policy decisions and explain their impact on resource allocation for care of patients with chronic mental illness.

Answer

VHA initiated the implementation of RPM (Resource Planning and Management), a prospective capitation management system, in the FY 1994 budget allocation process. It is important to keep in mind that FY 1994 is the first step in a three year transition and development process. It will take two years to transition away from the historical budget data and institutionalize a patient care workload funding base. The field, VSOs and the Congress respond best to advance notice about change in process and information systems. Any major shifts in workloads, budgets, and missions of individual medical centers require support within the Department, OMB and the Congress in order to be successful.

The initial FY 1994 projection called for a 0.7 percent increase in resources for CMI. This projected increase was arrived at through a field and clinical program staff review process. Throughout April and May 1993, the Planning Group of the RPM Field Oversight Committee, comprised of VACO and field representatives, reviewed in great detail preliminary work on workload projections. The Planning Group considered five projection methodologies for each of the 49 patient subclasses before making a recommendation on each. All workloads went through an extensive review and evaluation, including a facility level analysis, to determine whether the recommended methodologies best reflected workload trends for a majority of facilities. To minimize potentially large shifts in workload or dollars for this first year of RPM implementation, the group recommended moderating both upward and downward shifts to promote a smoother transition by reducing the financial impact on facilities. This was a guiding principle in the Planning Group's review of all programs. Its projections were recommended by the RPM Field Oversight Committee, concurred in by VHA's Budget Policy Review Committee and approved by the Under Secretary for Health.

The FY 1994 planning process is still underway. However, of the increases recommended for new workload under RPM, the mental health programs are included. In addition, there are two mental health related initiatives in the President's budget, one for PTSD, and another for the Homeless Program. The new system (RPM) is expected to help us better identify our resource requirements in the future. VHA's workload projections and review process identified overall workload funding requirements for FY 1994 that are somewhat greater than the FY 1992 base. Funding shifts were identified that moved resources from acute and chronic inpatient care to ambulatory care, chronic mental illness, and AIDS patient care workload categories. A significant amount (67 percent) of the FY 1994 resources (identified in RPM for new workload) is being recommended for allocation to the care of chronic mental illness patients. Additional resources are also planned for allocation to increasing workloads for AIDS patients and for Ambulatory Care patients. In contrast, decreases in our acute (non-psychiatric) short term care patients are planned for FY 1994.

Question

Please confirm our understanding that for certain RPM patient categories involving chronic mental illness, projected unit costs for FY 1994 will decrease under RPM. Please explain the basis for concluding that the unit cost for care of a schizophrenic patient, for example, would decline.

Answer

The starting points for the FY 1994 unit costs are the FY 1992 actual unit cost and the budget limitations that affect the amount of resources available for all the RPM patient groups. There were insufficient funds in the President's budget to support all of the projected workload increases at full unit cost. In sizing the workload to the available resources, the RPM process recognized that marginal workload changes do not necessarily occur at the average cost rate. Those patient categories expecting growth, such as schizophrenia, were recommended to show a marginal unit cost benefit. Generally, projected unit costs vary depending on whether workload is increasing or decreasing. When workload is increasing, in most cases the unit cost is decreasing. For situations where workload is decreasing, the mathematical result is an increase in the unit costs.

The FY 1994 field reviews conducted during June and July 1993 refined the workload and unit cost targets as needed. The Regional Directors' and AsCMC for Operations review of workloads and unit costs conducted during July and August 1993 provided an additional refinement, review, and adjustments as necessary.

Question

Please comment on the observation made by Dr. Falcon at the June 29th hearing to the effect that staffing for small psychiatry services in the Department's tertiary facilities is frequently better than at its large neuropsychiatric hospitals, with the result that sicker patients frequently end up in VA facilities with the worst staffing. Is such a situation clinically acceptable? What actions have been or will be taken to rectify such staffing disparities?

Answer

Overall, the variations in staffing ratios among VA medical centers, as measured by the number of mental health staff per psychiatric inpatient are three-to-fourfold, independent of the type or mission of the medical center. Thus Dr. Falcon's scenario is clearly possible between selected medical centers. The neuropsychiatric hospitals tend to have fewer psychiatrists and more social workers, nursing and rehabilitation staff than the tertiary centers per inpatient. The workload, as measured by patients treated, also tends to be larger at the larger tertiary hospitals because of higher turnover rates and shorter lengths of stays, but there are also wide variations. Psychiatric residents and various students on the wards also add to the higher staffing levels at our teaching centers.

Because many of our neuropsychiatric hospitals essentially are unable to accept new referrals of chronically mentally ill (CMI) veterans from other VA facilities due to insufficient turnover rates, our plan at this time is for each network of medical centers to take responsibility for all CMI veterans in the area and develop community support systems including active case management of difficult patients at all network VA medical centers while simultaneously defining a rehabilitation role for neuropsychiatric centers with regard to specific types of patients. We have published a revised Mental Health Manual; surveyed all mental health programs to ascertain local capabilities; started a long-term mental health enhancement project to introduce state-of-the-art ideas and modalities at our neuropsychiatric centers; are offering a national training program in September, and are proposing new initiatives this summer in support of this plan.

Question

VA has long said that it would not sacrifice quality of care at the expense of serving more patients. Yet data suggest wide variability from facility to facility in per patient resources devoted to care of the mentally ill. Would you find acceptable the existence of wide variation in the quality of mental health services provided veterans? If not, what measures will the Department institute to ascertain whether such variation in quality of programming exists and what steps will you take to strengthen weaker programs?

Answer

The quality of mental health services is affected by other factors than per patient resources. In the first place, the mental health field has no generally accepted measures of quality care although most clinicians think they would recognize quality if they saw it. All of our medical centers, including the neuropsychiatric facilities, are passing the Joint Commission on Accreditation of Healthcare Organizations standards with flying colors, many surpassing private sector scores. Furthermore, patient acuity, the types of disorders presenting, the amount of community alternatives and support, teaching and research demands, local geography, the size and mission of the medical center, the physical plant, practice standards in the community, leadership, and local talent and commitment also strongly affect the quality of care. Nonetheless, the low staffing ratios found at some of our medical centers increase the difficulty clinicians have in providing quality care. The 14 percent decrease in overall psychiatric beds since 1988 reflects a decision to close beds rather than decrease quality of care at many medical centers.

VA has never had an effective mechanism to redress core staffing problems. The new Resources Planning Management (RPM) funding system supports a management decision to move funds from some medical centers with high cost per workload ratios to those with low ratios, but we have no overall, facility-specific plan.

We do have three national centers evaluating those local programs that have received congressionally mandated funding in the areas of substance abuse, homeless chronically mentally ill, PTSD, and long-term psychiatric care. The centers are evaluating outcome criteria that reflect quality issues at those sites. A plan to increase the numbers of such centrally mandated and evaluated programs would partially address the staffing issues.

Question

Would you comment on the suggestions made by VVA that such programs as long term mental health care, substance abuse treatment, and PTSD programs should be expanded through bed conversions?

Answer

A suggestion to convert existing psychiatric beds to needed outpatient programs has merit only where there is sufficient staffing. Unfortunately, many of our neuropsychiatric hospitals have incurred significant staffing losses during the years when the reimbursement system rewarded short hospitalizations. They responded by closing beds to maintain basic staffing levels, and severely limiting new admissions and referrals from other medical centers. Thus, we may be seeing a national psychiatric bed shortage at this time, rather than a surplus that would lend to converting to outpatient programs.

Question for Ms. Sheldon

Would you comment on the cost-effectiveness of CWT programs?

Answer

The most recent program evaluation of the Compensated Work Therapy (CWT) program by the Office of Program Analysis and Evaluation Service of VA in June 1988 indicated that as VA health care programs increasingly are oriented toward providing cost effective health care in the least resource intensive setting, compensated work therapies are viable treatment modalities that are less resource intensive than most other outpatient treatment modalities.

The study indicated that "CWT can be an integral component of VA day treatment, day hospital, or other outpatient mental health programs. Because activities are purposeful and provide opportunities for earnings, CWT can help maintain patients in the community who have difficulty complying with day treatment programs with a strong orientation toward taking therapy and activities. CWT can provide opportunities for outpatients to perform in a close to 'normal' work setting. Continued attendance in CWT for outpatients is a very inexpensive therapeutic modality that permits VAMC staff to monitor patient status, behavior, compliance with prescribed medications, and to intervene before rehospitalization is necessary. For chronic recidivist patients who have resisted other day hospital and outpatient approaches in the past, CWT may help provide patients with motivation to maintain their highest level of functioning, and decrease need for more expensive resources, such as inpatient services and psychotheraphy."

The average age of patients seen in CWT ranges between 40-45. The majority are homeless or use someone else's address for mailing purposes. Characteristics include: 90 percent substance abusers, 75 percent incarcerated, a majority are minorities and most have few, if any support systems. They do not have incomes, therefore, need employment or else become part of the revolving door population.

For the most part, CWT is not staff intensive. In the Supportive Employment part of the program, veterans work at the industrial site of the contract. Veterans are supervised by the industry staff. Therefore a staffing ratio could conceivably be 1:40 within this framework. CWT program officials are working with VA to establish supportive employment opportunities that will provide savings to VA and work for veterans. For example, the Hampton VAMC contracted with CWT for $110,000 for work in Environmental Management Service and Engineering. Patients are paid prevailing wages, but no overhead expenses are required. As a result, Hampton realized a savings in excess of 45 percent.

Additionally, in sheltered work environments, one staff person will supervise up to 30/40 patients at any given time. Equipment and supplies are usually provided through the contract or are purchased out of Special Therapeutic and Rehabilitation Activities Funds (STRAF), funds made by CWT as part of a contract. Primary funding by VA is for staff and space.

The new Compensated Work Therapy programs that are linked with Transitional Residences (CWT/TR) provide a less expensive program since patients are living in transitional housing, paying their own rent, utilities and all other expenses. The First Progress Report on the Department of Veterans Affairs Veterans Industries (CWT)/Therapeutic Residence Program indicates that the estimated average direct cost of care in the CWT/TR program is $19.25 per patient per day, far less than VA inpatient, nursing home or domiciliary care, but also substantially less than typical charges for community halfway houses, sober houses or therapeutic residences offered by the private sector.

In CWT programs that have use of a nonprofit organization, additional costs can be saved through the use of grants for staffing, space, and OJT (on-the-job training) opportunities. Income made on contracts also can be used for staff.

Staff within CWT ranges from GS-11/12 as Program Manager to a GS-7 Therapy Assistant. Therefore, the cost of staffing is relatively inexpensive compared to other professional programs. In addition, many CWT programs pay for their own use of government vehicles, telephones, and other supplies.

During FY 1992 VA operated 53 CWT programs in which 7,125 patients worked 1,396,976 hours. These programs performed work totalling $7,040,930, an increase of $1.2 million from FY 1991.

When patients are discharged from CWT programs, they are better prepared to cope with employment issues and to meet their financial obligations. Since significant emphasis is being placed on job readiness, technical skills, behavior changes, resume writing and interview techniques, many VA patients not only are working under CWT, but are becoming trained in an occupation. One excellent example is a homeless veteran at VAMC Hampton, Virginia, who had been a helicopter mechanic earlier in his life. After several months in CWT, focusing on skills, stress management, and other employment issues, he was employed at a company making $93,000 per year. While this level of success is unusual, the primary focus of CWT on employment, and successful community re-entry has made a difference in the lives of many veterans suffering chronic health conditions.

Questions for Drs. Lipkin and Falcon

Question

What are the funding and staffing implications of instituting a case management model or other means of coordinating a patient's care?

Answer

Case management models of coordinating psychiatric care potentially can lower the average cost of care for many individual patients by decreasing their hospital usage. However, most mental health programs in the VA will need additional staff to provide enough case managers to do the job effectively. In addition, this model will increase the demand on mental health clinics, day treatment centers and other outpatient programs like substance abuse and CWT.

Overall, the national experience suggests that using a case management approach will cost considerably more to implement, but that by providing sustained, high quality outpatient care hospital use will decline. There is a possibility of some small net savings.

For the VA, there will have to be a substantial investment in staffing to permit an effective trial of case management.

Question

In his testimony, Dr. Jerome Vaccaro characterizes most health care systems as being extremely fragmented and as providing discontinuous, uncoordinated care. Is that a characterization you would apply to VA care of the mentally ill? Do you concur with his view that so-called "case management" is an answer to that problem?

Answer

As Dr. Vaccaro indicated in his testimony, most health care systems are quite fragmented with regard to the care they offer. Patients often receive discontinuous, poorly coordinated care, resulting in decreased clinical effectiveness and decreased cost efficiency. He feels this is a characterization that can be applied to many VA medical centers. There have been efforts mounted to combat this problem, such as the Central Office initiatives in the areas of psychiatric rehabilitation and care of the homeless mentally ill, but these efforts suffer from the budgetary shortfalls, as noted in Dr. Vaccaro's testimony.

Dr. Vaccaro also noted that there are many examples to which we may turn for answers to this problem. In brief, it requires Continuous Treatment Teams composed of clinical case managers who follow patients thoughout the course of their illnesses. This care is often required for the patient's entire life. It would serve us well to examine programs from Madison, Wisconsin, and replications throughout the world (including a number of VA sites). Despite the availability of these models, significant progress toward case management will take administrative commitment, financial resources (whether redeployed or new funds), extensive staff training and reorganization, and ongoing technical consultation.

Question for Dr. Falcon

You state that VA's "problem has not been a lack of innovation or commitment" but lack of funding support for care of the chronically mentally ill. Dr. Talbott, however, states that VA has not been a leader or done much pioneering in caring for this population. Are the two of you describing the same system?

Answer

Dr. Talbott and I are describing the same system, but not the same sub-population of veterans. Dr. Talbott seems to define the chronically mentally ill population as veterans who will require mental health care on an inpatient or outpatient basis throughout their lifetime, and includes veterans with diagnoses such as PTSD, homelessness and substance abuse.

Generally, VA's definition of chronic mental illness is limited to veterans with a diagnosis of schizophrenia, dementia or "other psychoses," who have been hospitalized for more than 90 days a year in the past four years. The more severely ill population of veterans eligible for entry into our Long-Term Mental Health Enhancement Program (LTMHEP) projects are those with a diagnosis of psychosis (schizophrenia, affective disorder, dementia, etc.) who within the past year were hospitalized for 150 days or had 5 admissions.

A logical question that arises from Dr. Talbott's statement above is, "compared with what?" Because of the differences in funding mechanisms, VA cannot be compared with the private sector, thus the comparison can only be made with state programming. Few states have innovative mental health programs for chronically mentally ill patients that are comparable to those offered by VA. Dr. Talbott's statement may reflect VA's failure at technology transfer more than VA's failure to be innovative. VA does not do a good job of disseminating information about its mental health programs to other VA medical centers, much less to the general public. There are many innovative long-term mental health rehabilitation programs at VA medical centers, but funding does not allow for a training process through which information can be transmitted to other medical centers. In recognition of such issues, the LTMHEP keeps the 30 VA long-term psychiatric care facilities informed about innovative LTMHEP programs at the other sites, and assists sites that did not receive funding, to develop strategic plans for upgrading services for the long-term psychiatric patient.

The major premise of Dr. Talbott's full statement to the Committee is that VA, as a medical system, has not focured its attention on the chronically mentally ill population as it has on other groups. Indeed, much of VA's innovative programming for mental health services results primarily from above-budget appropriations for PTSD, homelessness, substance abuse and long-term mental health care.

Preliminary information from our LTMHEP programs suggests that the models being employed in day treatment, transitional living and case management will prove successful, even in rural America where many of our neuropsychiatric facilities are located, and where resources needed to maintain a patient in the community are simply not available. What is clear from the LTMHEP programs is that given sufficient funding, systems can be developed that link appropriate clinical programming in the long-term psychiatric facilities to surrounding VA medical centers, and to available resources in the community.

Question for Dr. Katz

Would you expand on your point that psychiatry is best conceptualized as a primary care discipline? What are the implications of that observation?

Answer

Psychiatrists are, first of all physicians, and patients with psychiatric disorders, in general, have needs for medical as well as psychiatric care. Medical-psychiatric comorbidity, the coexistence of mental and medical illnesses is a fact of life whose impact on the VA is increasing as veterans with chronic mental illness age and become vulnerable to the common medical disorders of late life and as the cohort of World War II and Korean War veterans is reaching the age of the maximum incidence of Alzheimer's disease. Treatment for these patients would be most effective if basic medical care were offered by the same system that provides mental health services.

The reasons for proposing that psychiatry should serve as a primary care discipline are related to barriers that currently interfere with the delivery of medical care for psychiatric patients. One set of barriers is related to patient behaviors. Patients with psychiatric disorders such as schizophrenia have difficulties in negotiating medical care systems and in communicating their problems and needs to others. Those with Alzheimer's disease and related disorders also have difficulties with communication regarding their medical symptoms; for them, arranging for medical care is yet another source of stress for already overburdened family caregivers.

There are complementary barriers at the provider level. Physicians and systems are often ill-prepared to communicate effectively with psychiatric patients; in addition, they frequently do not have the time or the flexibility that is needed. As a result of these difficulties patients often neglect their physical health and are at risk for increasing disability. In fact, psychiatric patients including those with chronic mental illness and those with Alzheimer's disease must be considered a group that is medically underserved.

A solution would be to recognize that psychiatrists and psychiatric services can provide basic primary medical care for their patients. It would mean that the rapport and understanding that develops between patients and the clinicians responsible for their mental health care can facilitate their medical care as well. It would also mean that patients or caregivers would no longer have to try to guess whether new symptoms were related to worsening of psychiatric problems or to medical illness; they would be able to turn to one service for all of their basic care.

Many places, both chronic neuropsychiatric facilities and psychiatric services within general medical centers, already offer medical care within the psychiatric treatment setting. Facilitating these services may require administrative adjustments, such as redefining case loads and augmenting nursing support in psychiatric clinics, but these are in no way revolutionary. The benefits of conceptualizing psychiatry as a primary care discipline would be to ensure that patients with mental disorders receive the medical, as well as the psychiatric, care that they need.

Questions for Dr. Vaccaro

Question

As an expert on rehabilitation, your testimony suggests that rehabilitation programs can change patients' lives dramatically, but that it requires intensive staff support. In your experience, are Medical Center Directors willing to provide that needed staffing?

Answer

Let me first say that my direct experience with hospital directors is limited to my four year tenure at the West Los Angeles VAMC. Our new Director, Mr. Kenneth J. Clark, has been very supportive of our efforts. In fact, early in his tenure he made a concentrated attempt to understand our services by meeting with my staff and me, and touring our programs. This effort on his part may not be common for all medical center directors, but is crucial if they are to understand and support our efforts. As I noted in my testimony, many health care providers and administrators are not fully informed about the complexity of the work we do.

At my own medical center, we have been successful in advocating for administrative and financial support to expand our Compensated Work Therapy program so that it is able to secure contracts with other VAMC services. This means that other VAMC service chiefs will contract with CWT to provide services. The individual service provides the funds and the staff support to supervise the work activity.

Finally, I have long-term concerns about our VA health care system itself, in that we have generally supported acute care models of service delivery, leading to underfunding of long-term efforts, such as rehabilitation. This problem will become critical as the character of the veteran population changes: we continue to see more individuals with serious and chronic mental illnesses, whose needs are life-long and extensive. We should carefully evaluate this situation to prevent unwise diversion of resources away from those with chronic mental illnesses.

Question

Can you expand on your point that rehabilitation efforts can be very cost-effective?

Answer

I would like to answer this question in two ways: with anecdotal experiences and with outcome data. The latter area is still in its infancy but shows promise.

In the case of John (the patient I discussed in my testimony), he was being hospitalized dozens of times per year when he wasn't given access to rehabilitation programs. As an inpatient bed in most psychiatric hospitals will cost $400 or more per day, the cost of his care in a typical year might approach $100,000. In the years when John received rehabilitation services and coordinated mental health treatment, these costs were dramatically reduced. For example, a full year in one of our most intensive rehabilitation program costs less than $5,000. Add to this the increased productivity (with wages earned), enhanced quality of life, and reduced family burden, the savings can be great.

From an outcome research perspective, the findings are similar. I should say that the fields of health services and clinical outcomes research in this area are still in their infancy. However, it seems reasonable to say the following. Direct costs (e.g., the costs of providing treatment and rehabilitation) for the kinds of rehabilitative programs I cited are no more costly than the usual ways we do business, and are more likely to be less costly. For a detailed review of this area, I suggest that you see the article by Rupp and Keith in the June 1993 issue of Psychiatric Clinics of North America. In this article, the authors succinctly analyze available information regarding total costs of mental illness and its treatment.

Question for Ms. Riley

Would you describe the psychiatric case management program at Topeka? How did the program develop, and how is it staffed?

Answer

The Continuous Supported Self-Care Program (CSS-CP) was developed to meet the unmet needs of the long-term mentally ill veterans at the Topeka VAMC. The CSS-CP is fully staffed with an eleven member team that includes a psychiatrist, two clinical nurse specialists, a clinical psychologist, two master level social workers, four social work associates and a program evaluator. The program was initiated after a successful pilot project was completed by the Colmery-O'Neil VAMC in cooperation with the University of Kansas School of Social Welfare. The pilot project utilized social work students who provided services to a limited number of veterans referred from the extended care psychiatric units. The social work students from Kansas University used a social rehabilitation model called the "Strengths Perspective." This approach capitalizes on the social, psychological and cognitive strengths of the client and fosters their independence. The CSS-CP case management team assesses the capabilities of the client, which historically have enabled him or her to live successfully outside the hospital. This is in contrast to the traditional approach of focusing on those problems that have contributed to "failures" in living in the community and trying to address treatment planning based on problem resolution.

The chronically ill individual often has difficulty setting priorities, making decisions and forming relationships. These factors make it difficult for them to make the transition from hospital to community and to adapt to their environment.

Case managers build relationships with clients, teach them practical living skills and guide them toward community resources. Case managers may teach clients to ride a bus, shop for groceries, assist them in choosing an apartment, negotiate decisions with others and set realistic goals. These rehabilitation efforts are accomplished by example, problem solving discussion groups, "OJT" (on job training) in the community and learning to break each goal into small achievable steps.

Our clinical nurse specialists and psychiatrist monitor medication compliance and the client's health status. They teach and counsel clients regarding their health and medication issues.

Our psychologist conducts social skills training groups. She also provides more intense "one on one" counseling for their psychological and emotional needs.

The CSS-CP has been extremely successful in reducing the length of stay and the number of hospitalizations of chronically mentally ill veterans. CSS-CP's "Strengths Perspective" improves the quality of life for the veterans by providing increased opportunity (and expectation)for personal responsibility. An important aspect of our program is the "consumer counselors." This is a group of chronically mentally ill veterans who have successfully negotiated the transition from hospital to community and are now stabilized in terms of their illness. Based on their own experiences as clients, the consumer counselors act as expert consultants to the staff. They also act as "buddies," teachers and counselors to the clients in a way that is unique within the CSS-CP. CSS-CP is placing more emphasis on consumer participation. Training has been initiated to more fully integrate consumer counselors in our program.

In addition to case management the CSS-CP is aggressively involved in developing more resources in the community. The extreme shortage of affordable and decent housing for the chronically mentally ill has prompted the CSS-CP to submit a housing proposal to HUD. If funded, this residence will be the first demonstration project of its kind in the VA, utilizing case management services.

As of this date, we have 108 clients in the CSS-CP. Our case managers are assigned 25 to 30 clients. We are continuing to receive referrals from the psychiatric units and there appears to be an urgent and ongoing need for our services.